

Annual Report and Accounts 2018/19



Getting to Good

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1. Performance Report

Overview

Welcome to our Annual Report and Accounts for 2018/19. This document gives an overview of the successful steps we’ve taken, and our continuing journey to meet our vision of being a national leader in the delivery of safe, high-quality and compassionate integrated care. As is evident in the local and regional context sections on pages 14 and 15, the Trust faced a series of challenges, in finances and services, over the last year. Though the NHS as a whole is taking steps to integrate and improve services, the health service still finds itself under pressure across the country, as is detailed on page 13. Bearing in mind these hurdles, the Trust has made strong progress on its Getting to Good journey.

The Trust has continued to develop and strengthen its leadership over the last year as well as its partnerships with other island organisations, notably the Council and Clinical Commissioning Group. All our brilliant staff have worked tirelessly to improve quality, services and patient experience. The Isle of Wight NHS Trust has been no different from other NHS trusts across the country in meeting the competing pressures of increased demand for services and the need to meet performance and financial targets. At times, we have struggled with these pressures - but our focus on improvement, quality, safety and governance has been unceasing.

The Trust continues to work towards addressing these issues, as well as achieving the goals set by the Care Quality Commission in its reports and visits of the last three years.

Notwithstanding the additional challenges, work has continued to address the future sustainability of the Trust and its services. Together with partners, including the local authority and the Isle of Wight CCG, we have designed and implemented the Isle of Wight Health and Care Sustainability Plan. This plan has been developed in response to the NHS Long Term Plan and the national drive for the integration of services.

The Isle of Wight Health and Care Sustainability Plan sets out the challenges in delivering health and care on the Isle of Wight over the next three years, and identifies the priorities for meeting these challenges. The three organisations have come together as the Isle of Wight Local Care Board to work and plan together to ensure the integrated development and delivery of health and care services on the Isle of Wight. We will set out the changes needed to deliver this programme, in terms of how services can be best organised and provided, ensuring that the overall objective, to deliver high-quality care in a sustainable way, meets the needs of our population.

Simultaneously, the Trust is working closely with NHS Improvement following the recent decision to downgrade the Trust finances to special measures. We are working in partnership as a health and social care system to plan and deliver improvements together, which will provide us with clinically sustainable services. Working with the NHS Improvement Financial Special Measures team will provide us with additional focus and support to ensure that our clinical services are also financially sustainable.

We would like to express our gratitude to all of our colleagues at the Trust, both staff and volunteers. We have faced many challenges in 2018/19 and would like to offer our sincere thanks to our staff who continue to deliver high standards of care in, what can often be, a pressured environment.



Getting to Good

New emergency admission form improves quality of care for patients

Emergency teams at St Mary’s Hospital have revamped their admission form to include more patient information, helping to improve and standardise the quality of care.

The new form has been developed in conjunction with staff across the department, taking into account numerous changes within the NHS over the past few years.

Alongside all standard patient information, the form now identifies further areas of risk, such as controlling patient infections from conditions like sepsis and planning for a patient’s discharge from hospital based on their social needs. It is now

20-pages long and colour-coded to indicate which sections the relevant healthcare staff member is to complete.

Consultants and healthcare professionals from a number of specialties within the Trust fed into the development of the new admission form and the improvements also reflected recommendations from a national level. These include Care Quality Commission (CQC) reports, Sir Bruce Keogh’s Urgent and Emergency Care Review in 2013, and learnings from the Mid-Staffordshire scandal, among other sources.

Trust profile

The Isle of Wight NHS Trust faces unique challenges as a healthcare provider. As the only organisation with integrated community, ambulance, mental health and acute services, it is important that we partner with other local organisations to ensure the sustainable delivery of health and care services to our population.

Our health and care system serves a population of 140,000 people, with seasonal population increases. Despite the presence of an integrated Trust (acute, community, mental health, ambulance), with a co-terminal Council for the island geography, historic challenges remain. These include recent leadership changes, Trust restructuring, marginal gains from prior care redesign and lack of clarity on the acute service model for the island. During summer months, the Trust alone deals with 20% more attendances at the emergency department owing to a seasonal population increase.

The care system consists of the Trust, which provides acute care, community, mental health and ambulance services, and the Council, which provides social care and public health services. Like many NHS organisations, the Trust also experiences significant winter pressures across its service provision and finances.

In response to the 2018 CQC rating of 'Inadequate', the Trust has taken several steps towards improvement. We have evolved our improvement journey vision from "Getting to Good" to "Getting to Good, Aiming for Outstanding", to reflect our ambition for the longer term. Our Trust values and vision statement have been updated to echo this. These underline our commitment to working with partner organisations to deliver safe, high-quality and compassionate, integrated care. It should be noted that CQC inspectors highlighted several areas of progress and commended staff commitment quality care, giving us a 'Good' rating in this area.

The Trust continues to work to address the CQC's comments from 2016 and has adapted its approach in accordance with the publication of the NHS Long Term Plan earlier this year. The Isle of Wight Health and Care Sustainability Plan is a partnership between the Trust, Isle of Wight Council and the Clinical Commissioning Group. Our sustainability plan identifies the local challenges we face and how they can be met over the coming three years through collaboration and partnership. As the sustainability plan develops we will engage members of the public and be able to share more information as we move through the summer of 2019. More information on our sustainability plan can be found on our website and on page nine of this report.

Financially, the Trust has not had an easy year. Like many NHS organisations, the Trust has, for some time, had a worsening financial deficit, as we invested in necessary improvements, additional staff and care for increasing numbers of patients. Subsequently, NHS Improvement took the decision in March 2019 to move the Trust into financial special measures.

Our costs have risen significantly and we have not been able to deliver all the efficiency savings that we hoped to. Some of this is on account of the specific costs relating to our island situation, including the difficulty of recruiting sufficient permanent staff, meaning we spend more on temporary staffing fees.

We also recognise that we need to continue to develop alternatives to treating people in hospital. Our community and mental health services need more development so that patients and service users are supported with a range of care options tailored to their need. We are working in partnership as a health and social care system to plan and deliver improvements together, which will provide us with clinically sustainable services.

The Trust has worked towards consolidating its new leadership structure throughout 2018/19. Following a review from Carnall Farrar, and the appointment of a substantive Chief Executive Officer, a new executive structure, which reflects the Trust's needs, has been implemented.

Getting to Good

New guidelines help treat and reduce the risk of infections

The Isle of Wight NHS Trust revised and re-launched its antimicrobial guidelines to help better target the treatment of infections and minimise the risks involved with antibiotic use.

The new treatment guidelines now offer a more focused set of antibiotic choices for infections and new protocols for patient doses of two specific antibiotics – gentamicin and vancomycin.

The new guidelines are based on a number of key national recommendations to tackle antibiotic resistance but remain unique to the Trust's circumstances, with feedback from staff being incorporated.

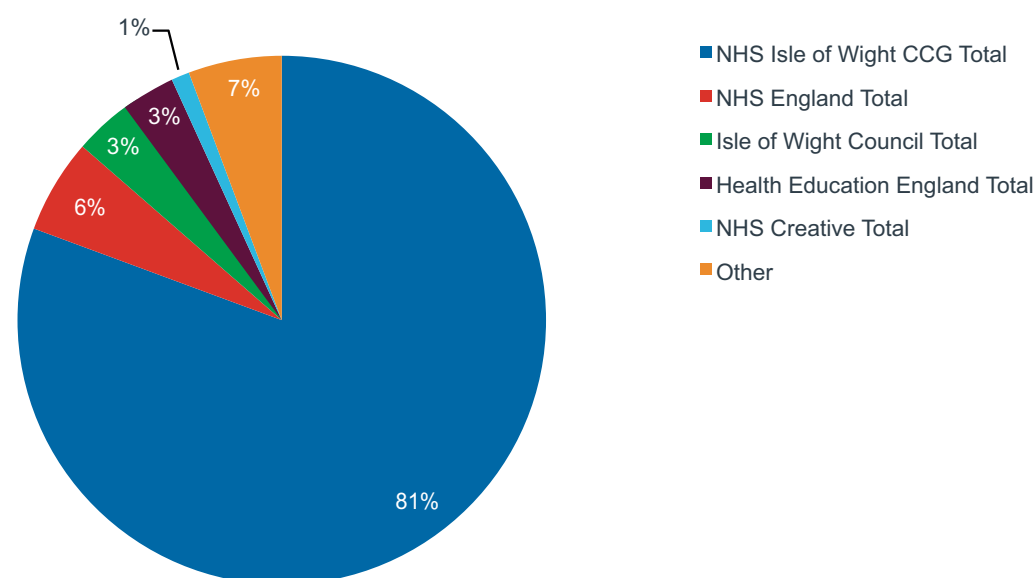
In order to make the best use of the guidelines, a "microguide" app has been developed for use online, via mobile devices and the Trust intranet, ensuring that the specific and detailed guidelines are readily accessible and as user-friendly as possible. The app was developed nationally but the content has been produced locally to meet the needs of the Trust and can be updated promptly as required.

Our service profile

Income

| Income Source | 2015/16 £m | 2016/17 £m | 2017/18 £m | 2018/19 £m |
|--------------------------------|--------------|--------------|--------------|--------------|
| NHS Isle of Wight CCG Total | 134.7 | 135.2 | 138.2 | 140 |
| NHS England Total | 11.6 | 12.3 | 10.3 | 11.3 |
| Isle of Wight Council Total | 5.9 | 6.6 | 7.5 | 5.7 |
| Health Education England Total | 3.7 | 3.8 | 4.1 | 4.7 |
| NHS Creative Total | 2.6 | 2.5 | 1.9 | 1.8 |
| Other | 11.8 | 10.7 | 9.4 | 12.2 |
| Total | 170.3 | 171.1 | 171.4 | 175.7 |

Income Source 2018/19 £m



Demand

| Isle of Wight NHS Trust Activity Growth | | | | | | | | | |
|---|-----------|-----------|---------|-----------|---------|-----------|---------|-----------|---------|
| | 15/16 | 16/17 | Growth | 17/18 | Growth | 18/19 FOI | Growth | 19/20 | Growth |
| Inpatient - Planned (Spells) | 10,296 | 12,827 | 24.6% | 12,160 | (5.2%) | 17,817 | 46.5% | 17,818 | 0.0% |
| Inpatient - Emergency (Spells) | 13,651 | 13,703 | 0.4% | 14,348 | 4.7% | 14,393 | 0.3% | 14,395 | 0.0% |
| Outpatient (Appointments) | 140,091 | 137,016 | (2.2%) | 133,254 | (2.7%) | 134,194 | 0.7% | 134,203 | 0.0% |
| 111 (Calls) | 58,750 | 70,686 | 20.3% | 75,193 | 6.4% | 79,311 | 5.5% | 79,311 | - |
| Ambulance (Calls) | 24,979 | 27,760 | 11.1% | 30,545 | 10.0% | 26,865 | (12.0%) | 20,754 | (22.7%) |
| A&E (Attendances) | 43,776 | 42,896 | (2.0%) | 46,717 | 8.9% | 47,373 | 1.4% | 47,374 | 0.0% |
| Walk in Centre (Attendances) | 3,855 | 3,554 | (7.8%) | 1,836 | (48.3%) | 1,342 | (26.9%) | 1,343 | 0.1% |
| Critical Care (Bed Days) | 3,657 | 3,928 | 7.4% | 3,474 | (11.6%) | 3,556 | 2.3% | 3,558 | 0.1% |
| Pathology (Sets) | 1,334,301 | 1,397,005 | 4.7% | 1,394,474 | (0.2%) | 1,434,557 | 2.9% | 1,434,557 | - |
| Imaging (Requests) | 111,988 | 113,994 | 1.8% | 114,791 | 0.7% | 118,309 | 3.1% | 118,309 | - |
| Other Outpatients (Appointments) | 36,520 | 33,438 | (8.4%) | 30,964 | (7.4%) | 28,080 | (9.3%) | 28,080 | - |
| Community - Nurse (Contacts) | 124,729 | 117,251 | (6.0%) | 113,016 | (3.6%) | 117,922 | 4.3% | 117,922 | - |
| Community - AHP (Contacts) | 90,357 | 96,035 | 6.3% | 95,035 | (1.0%) | 98,056 | 3.2% | 98,056 | - |
| Community - Other (Contacts) | 1,742 | 1,414 | (18.9%) | 742 | (47.5%) | 551 | (25.8%) | 551 | - |
| Mental Health - Outpatients | 6,203 | 6,323 | 1.9% | 6,062 | (4.1%) | 5,697 | (6.0%) | 5,697 | - |
| Mental Health - Inpatients | 639 | 608 | (4.9%) | 449 | (26.2%) | 345 | (23.2%) | 345 | - |

Footnotes

- 18/19 Growth in Inpatient planned activity due to the reclassification of Chemotherapy attendances from Outpatient to Day case
- Reduction in Ambulance calls in 18/19 due to change in reporting mechanism with move to new CAD
- Reduction in Community Other activity in 18/19 due to termination of wheelchair service
- Reduction in Mental Health Inpatient Activity during 17/18 and 18/19 due to a reduction in inpatient beds during 17/18

Staff

| Average Staff Numbers audited (WTE basis) | Permanent | Other | 2018/19 TOTAL | 2017/18 TOTAL |
|---|-----------|-------|---------------|---------------|
| Medical and dental | 224 | 49 | 273 | 271 |
| Ambulance staff | 107 | 0 | 107 | 104 |
| Administration and estates | 665 | 23 | 688 | 672 |
| Healthcare assistants and other support staff | 622 | 107 | 729 | 702 |
| Nursing, midwifery and health visiting staff | 753 | 185 | 938 | 903 |
| Nursing, midwifery and health visiting learners | 0 | 0 | 0 | 0 |
| Scientific, therapeutic and technical staff | 345 | 19 | 364 | 362 |
| Healthcare science staff | 0 | 0 | 0 | 0 |
| Social care staff | 0 | 0 | 0 | 0 |
| Other | 1 | 0 | 1 | 2 |
| Total average numbers | 2,717 | 383 | 3,100 | 3,016 |
| Number of employees (WTE) engaged on capital projects | 6 | | 6 | |



Our strategic direction and longer term plans

Our vision and associated strategic goals articulate and drive our sense of purpose. They enable us to configure our organisation appropriately, and deploy resources in ways that make services more productive and good value-for-money.

In April 2017, the Trust was rated ‘Inadequate’ by the Care Quality Commission and placed in quality special measures. The CQC specifically identified weaknesses in the Trust’s strategy. These observations were also reflected in the later governance review, received by the Trust Board in February 2018. The Trust’s strategy was effectively paused pending a strategy review process in 2018. The Trust was under enhanced financial oversight in 2018 and, in March 2019, was placed in financial special measures following a further deterioration in the financial position. Our direction of travel has, therefore, been driven by the need to achieve clinical and financial sustainability. To this end, we have been working with our partners across the health and care system, including the Isle of Wight Clinical Commissioning Group and Isle of Wight Council, to develop a shared sustainability plan for the island. This will help us to collectively make the best possible use of the resources available to us in the provision of health and care services to meet the needs of our residents.

The work to develop a system sustainability plan has built on the Local Care Plan and the My Life a Full Life work to develop person-centred, co-ordinate health and social care. In September 2018, the Trust, Isle of Wight CCG and Isle of Wight Council engaged support to deliver:

- 1. A clear system vision
- 2. A road map for an Isle of Wight Integrated Care System (ICS) that will best support the delivery of the vision
- 3. An agreed system Sustainability Plan

This work has refreshed and built on the progress made across system-wide health and care transformation programmes to date, addressed weaknesses and accelerated the production of a coherent aligned approach. This work has also enabled system leaders to consider the options for the delivery model for an Integrated Care System (ICS) and develop a road map for achieving this.

It has provided a system-wide financial recovery and sustainability trajectory to enable the system to have confidence in robust plans, which can be effectively communicated to local residents and stakeholders in a way that is accessible, addresses key local concerns and establishes greater confidence in the system.

The vision for the system - “people will live healthy and independent lives” - was agreed in late 2018 and the Sustainability Plan was delivered in January 2019 focusing on three domains to achieve care quality/safety and financial sustainability – care models, productivity and networks. An Implementation Plan has been developed and work is underway to deliver year one of the plan. The Trust 2019/20 plans are aligned to the System Sustainability Implementation Plan.

This vision for the system is aligned with the Trust’s vision, that:

“Working with our island partners and others, we will be national leaders in the delivery of safe, high-quality and compassionate integrated care; putting those who use our services at the centre of all we do.”

This vision is underpinned by five strategic objectives:

- Provide safe, effective, caring and responsive services – “Good” by 2020
- Ensure efficient use of resources
- Achieve NHS constitutional patient access standards
- Achieve excellence in employment, education and development
- Lead strategic change on the Isle of Wight

During 2019/20, we will continue to work with our island-based partners and network partners on the mainland to develop the contemporary service models required to ensure sustainable health and care service provision for island residents and visitors.

Getting to Good

Community rehab team improvements see boost for patients and staff

The Community rehab team has introduced more efficient processes leading to reductions in waiting list numbers and improvements in staff satisfaction.

In line with the vision of the Community Division, the Isle of Wight NHS Trust and national best interest drivers, community rehab is one of the Island's key services to help deliver care and treatment closer to home. The rehab service aims to be slick in its processes, responsive in its care and effective in its treatment.

In order to achieve these goals, areas that needed to be addressed included unclear processes, high referral rates and high workloads. Individual disciplines had separate waiting lists, which resulted in a disjointed service and potentially long waits for patients. Staff reported concerns at the lack of teamwork and had ideas how to remedy this but high workloads meant little time to act.

Improvements have included introducing a single multi-disciplinary file and a single holistic assessment on first contact. This gives patients immediate access to any disciplines within the team as needed. The aim was to improve patient experience through joined up working, preventing duplication and ensuring everyone who came through the service had a thorough assessment of needs, helping to reduce re-referrals.

Within three months the waiting list numbers for occupational therapy and physiotherapy reduced by 52% even though the number of referrals remained constant. This means a reduced wait for patients in accessing interventions which will help maintain their independence in the community, preventing both admissions and readmissions.



Our clinical strategy

The clinical strategy has continued to drive forward the collective responsibility of health and social care providers on the island and mainland to ensure high-quality, effective and safe care for all.

As partners of the Local Care Board, overcoming barriers to provide seamless healthcare remains an important focus. There has been considerable emphasis on reducing the time patients require hospital treatment and speeding up their return to the community. Achieving efficiencies in resources, while maintaining systematic, safe practice, has been a key priority.

Safety has continued to be the highest priority and significant investment has been placed in Human Factors training and development of consistent handovers and communication between staff.

The clinical strategy has been underpinned by learning from untoward incidents and the ‘learning from deaths’ framework. In addition, the Trust is committed to the GIRFT (get it right first time) programme that drives clinical improvement by comparing with peers across the country.

The restructuring of the Trust into four divisions, with the development of strong clinical leadership within the care group, is a major step towards achieving a clinically-led organisation, with clinicians taking responsibility of their clinical areas. Each division has developed its own strategic priorities that are part of a continuous quality improvement programme.

A critical aspect of the Trust is determining a cost-effective delivery of hospital services. Modern hospital healthcare on the island requires a sustainable model, which depends on working in close collaboration with partner organisations within Hampshire and the Isle of Wight. A continuation of the Acute Services Review has been undertaken and is culminating in a framework for clinical services, which can be provided on the island, with support from secondary and tertiary care providers on the mainland. The strategy has also identified the need for enhanced transfer processes of patients and timely appointments. The development of virtual clinics, which avoids the need to travel, is at an early stage of development and will be improved over the course of the next year.

The need for partnership working has also been identified in the Mental Health and Learning Difficulties division. However, within the division, a clear plan to reduce the number of admissions and enhancing community mental health services has been a priority.

Ultimately, the Trust is constantly working to maximise its unique position of being fully integrated to enable patients to have as much care as possible delivered close to home, and this will result in enhancing the services provided by the community division and working closely with primary care colleagues.

Our values and behaviours

We commenced an extensive programme during 2018 to improve our organisational culture using the ‘Leadership and Culture Toolkit’ developed by the King’s Fund and NHS Improvement.

After engaging with more than 700 staff and patients/service users, we refreshed our vision, values and behaviours so they reflected our ‘Getting to Good’ journey.

Our vision was developed by our Trust Board:

“Working with our island partners and others, we will be national leaders in the delivery of safe, high-quality and compassionate integrated care; putting those who use our services at the centre of all we do.”

Our values and behaviours were developed from the feedback we had received through the Leadership and Culture programme.

Compassionate: We want to provide compassionate care by creating a climate that encourages actively listening to each other, understanding each other’s perspectives, empathising, and taking appropriate action to help and support each other. We want to enable staff to challenge so that behaviours that are paternalistic to patients and staff and risk-averse behaviours are eliminated.

Team working: We want our leaders to act as role models, working collaboratively with other teams, building meaningful relationships based on listening carefully to each other, asking questions to understand priorities and perspectives, offering support and helping each other.

Improving: We want staff to develop continuously, learn and try new things to become more efficient, by fostering a culture of innovation while ensuring that training, systems and processes enable new ideas to be highlighted and, if appropriate, implemented. We want staff who know what is expected of them, what they are responsible for and how they are going to be held accountable. We want to ensure that our staff have the resources they need to do their job and that these resources are used effectively. We want to ensure the organisation lives within its means. Our staff need to know what their part is in achieving our vision.

Valued: We want people to be treated as individuals, for leaders to demonstrate respect for staff and vice versa, recognising the needs of those who use our services. We want to ensure that all our staff, and those who use our services, are treated fairly.

National context

2018 saw significant changes across the healthcare landscape. Brexit talks have placed a question mark over future policies towards the immigration of skilled workers, including healthcare professionals. This matter is particularly pertinent to the Trust, as we have a high percentage of overseas workers. Elsewhere, NHS England and NHS Improvement have grown ever closer together, collaborating to work with local healthcare systems, including our own in the Hampshire and Isle of Wight footprint. In recognition of its 70th birthday, the NHS was granted an additional £20.5 billion funding over the following five years. The NHS Long Term Plan, published in January 2019, provides good insight into how funding will be allocated across the service over the coming decade.

Getting to Good

National acute-illness severity monitor rolled out across Isle of Wight NHS Trust

A new method of assessing and monitoring adult patients is now being used across the Isle of Wight NHS Trust. The National Early Warning Score 2 (NEWS 2) was created by the Royal College of Physicians of London to create a standardised way of assessing the severity of adult patient illness. The simple scoring system and, most importantly, its standardisation across all departments and across the NHS, was designed to serve as the ‘gold standard’ for patient care. NEWS 2 also creates a clear opportunity to spot Sepsis and trigger a Think Sepsis treatment package for patients.

All adult patients now have their blood pressure, temperature, pain, consciousness, blood oxygen and urine recorded and monitored in a standardised way. All patients are scored for severity and changes to the score are highlighted and used as a trigger for different levels of intervention.

Recording and monitoring patients’ key signs is not new, but standardisation across the NHS, with everyone using the same system and same scoring method, helps care teams to develop a clear and mutual understanding when monitoring the severity of patients’ illness, eliminating any confusion between specialties, services, sites and new and existing staff.

Under the mandate of the Long Term Plan, we are all now part of a national drive towards further integration of services. The Long Term Plan instructs healthcare organisations to partner with local authorities and create local strategies to explain what actions they will take towards this goal through the first five years of the Long Term Plan, itself spanning the next decade.

Accordingly, the Trust has partnered with the local authority and Clinical Commissioning Group to create the Isle of Wight Health and Care Sustainability Plan.

Our Trust is a member of NHS Providers, the representative body for NHS Trusts and NHS Foundation Trusts. The following sets out their view of the contribution the NHS makes to national life, and the investment and support needed.

Regional context

In April 2018, the Isle of Wight CCG became a member of the Hampshire and Isle of Wight Partnership of CCGs. The partnership is made up of five CCGs and manages a budget of £1.4 billion, to serve a population in excess of one million. The publication of the NHS Long Term Plan earlier this year highlights the increasing nationwide drive to improve the integration of all aspects of care – health, social care, primary care and the voluntary sector - for the benefit of local people.

The Isle of Wight Local Care Board (a collaboration of the Trust, Council, and CCG) has produced the Isle of Wight Health and Care Sustainability Plan, outlining the anticipated challenges and plans for delivering services to our population over the next three years. The Local Care Board will work and plan together to ensure the integrated development and delivery of health and care services on the Isle of Wight. We will set out the changes needed to deliver this programme, in terms of how services can

best be organised and provided, so that the overall intention, to deliver high-quality care in a sustainable way, ensures that our population needs are met.

We are pleased to see that the NHS Long Term Plan reinforces and develops many of the priorities already identified locally, including developing strategies to deliver more care out of hospital, closer to home and with an emphasis on prevention.

As part of the development of the Sustainability Plan, a review completed by the Local Care Board recognises the valuable feedback already received from our local community over the past few years. This includes the work undertaken on the new model of care for the island, the strategy for primary care, the work undertaken on the redesign of both acute and community services and the vision for social care. We have greatly appreciated the involvement of island residents during that time, and we recognise it is important to continue the dialogue as things move forward – a commitment all organisations share.

One Island – One Public Service

One Public Services (OPS) aims to organise services to meet the continuing needs of our island residents so that people are empowered to realise their life opportunities. Through greater collaborative working, OPS will:

- continually develop more efficient and effective joined-up public services applying a ‘same front door’ approach (whether virtual or real) serviced by all public service organisations
- share facilities, skills, knowledge and aligned system approaches that are seen as a success
- champion public service delivery for everyone, everywhere.

Local context

As mentioned previously, the Isle of Wight local healthcare landscape is unique in its seasonal peaks and troughs, which subsequently presents the Trust with exceptional challenges.

Despite historic progress in some areas, such as hospital front door activity, there is a strong case for change. Five per cent of the population with complex needs uses more than one-third of total health and care resources (over £100m), without a fully comprehensive care model for their needs. A bed audit and independent clinical review highlighted that 43% of patients who were medically fit to leave have waited for over a week to be discharged.

Our long term vision is that our population will live healthy and independent lives. Right now, we will start this journey by achieving clinical and financial sustainability for our health and care system. Our sustainability plan consists of three domains – care models, productivity and networks. Care models include community supported care, mental health and supporting return to home. Productivity focuses on Trust productivity, CCG QIPP priorities and council social care productivity. The ambulance service and mental health care model will be networked with other providers to accelerate relevant service change.

We have also been gathering the views of current leaders and senior staff across the system on the current position and operational environment. This was supported by care strategy experts, Carnall Farrar, who are funded by NHS England.

The Isle of Wight Sustainability Plan priorities and timescales for change include:

Phase One 2019

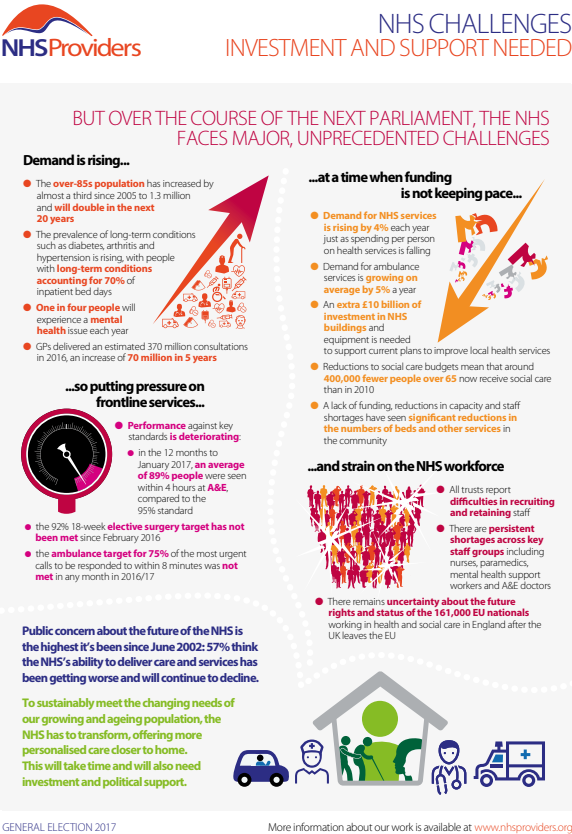
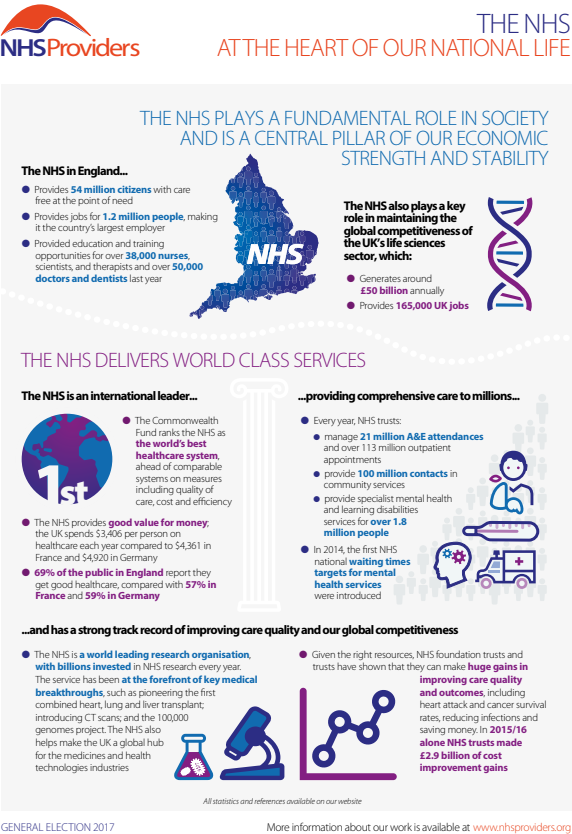
- Supporting return to home
- Onwards care and independent living
- Trust productivity
- Council social care productivity

Phase Two 2019 to 2020

- Mental health
- System efficiency
- Trust productivity
- CCG productivity
- Council social care productivity

Phase Three 2021 to 2021/22

- Community supported care
- Acute services
- Networked ambulance
- Trust productivity



Our next steps focus on high-impact areas for care quality and safety, and financial sustainability. These are productivity initiatives for the Trust, CCG and the Council, and work to reduce the length of stay for medically fit patients via a multidisciplinary discharge team and enhanced flow and discharge processes.

More information about the demographic and socio-economic profile of the island can be found on the Isle of Wight Council website: www.iwight.com/Council/OtherServices/Isle-of-Wight-Facts-and-Figures.

Corporate social responsibility

Positive engagement with our local community continues to strengthen through the volunteers and careers services.

Volunteers and schools help to facilitate various events such as fundraising projects, Santa's grotto for NHS staff families and open days that enable the public to engage in interactive events to learn about the various professions in the NHS. These also provide information on how to sign up to the Trust temporary staffing bank and to get further information on substantive positions within the organisation.

Our engagement with the public has been accelerated by the introduction of Facebook, Instagram and LinkedIn pages that are dedicated to careers and recruitment within the Isle of Wight NHS Trust. These pages are regularly updated with details on vacancies, apprenticeships, open days, success stories and work experience opportunities.

Facebook: www.facebook.com/TEAMIOWNHS
Instagram: [@IOWNHS_Trust_Careers](https://www.instagram.com/IOWNHS_Trust_Careers)
LinkedIn: [Isle of Wight NHS Trust](https://www.linkedin.com/company/Isle-of-Wight-NHS-Trust)

Future careers

The careers service is continuing to create and develop meaningful relationships with educational establishments across the Isle of Wight and the South Coast with the aim of promoting NHS careers.

With more than 350 careers available, the service showcases roles and professions in an engaging and inspiring way. Through interactive and collaborative workshops, we are able to not only leave an impression on young people but also give them a pathway in which we will support them into a future career with the NHS.

We continue to build strong links with schools and have been delighted to be the only employer who attends the Isle of Wight Careers Forum. We are also very proud to be a key stakeholder in the Isle of Wight careers partnership launch.

The workshops and programmes that we facilitate not only offer an insight to that specific profession but also strengthen university and job applications. These programmes promote the NHS as a place to work and make the young people who engage with the service stand out as excellent potential candidates for future engagement with their local Trust or the wider NHS.

The pre-employment programmes that we offer are:

- Careers in Health Care Induction Programme (CHIPS)
- Work experience
- Hospital tours
- Q&A sessions
- Dementia awareness
- CPR training
- Medical ethics workshop
- School assemblies
- One-to-one advice and guidance
- Careers fairs
- Health careers clinics (in collaboration with the Southern University Network and Medical Mavericks)
- Mock interviews

All of these programmes are offered to all Isle of Wight secondary schools and colleges and can be altered to suit the needs of the students. These can be delivered in schools or on site and we aim to not only deliver the programme but also offer ongoing advice, guidance and further learning opportunities.

We have also started to establish programmes with primary school pupils which was prompted by the NHS70 campaign. We have been into schools to deliver assemblies that focus on NHS careers, tackling gender stereotypes, and have also attended aspiration days and job fairs, whereby we can promote careers and engage with the community.

Volunteering

The Isle of Wight NHS Trust is very privileged to have the support of 300 volunteers who give their time to the trust to assist our patients, visitors and staff. Volunteers can be found across all divisions (acute, mental health, community and ambulance) and do incredible things every day to help our services.

Our relationship with volunteers is strengthened by regular communication, including a monthly newsletter with details on Trust-wide news, training opportunities and good news stories. We also run quarterly drop-in sessions, which are supported by directors. Feedback has shown that volunteers feel listened to and valued, and these drop-in sessions have improved relationships between the volunteers and the Trust.

This year, we were delighted to learn that one of our volunteers was nominated for 'Helpforce Young Volunteer of the Year', achieving third place in this nationwide scheme. We first met this volunteer through the careers service, and after volunteering at the Trust, he gained the skills and confidence to become a Healthcare Assistant. He has now applied for the Nursing Degree Apprenticeship scheme. This case study highlights the positive impact that the Volunteer and Careers Service provides in supporting the attraction and recruitment of staff to the Trust.

We continue to develop roles for volunteers by working with divisions to ensure that the time volunteers devote to the Trust is effective, efficient and meaningful.

To ensure that we are leading volunteers alongside national guidelines, we are members of the National Association of Voluntary Service Managers (NAVSM) and regularly attend quarterly meetings and an annual training seminar.

We have maintained our strong links and partnerships with Age UK, Mountbatten, Isle of Wight College, Helpforce and Isle of Wight Community Action group.

Developing research excellence on the island

During 2018/19, 23 studies were opened at the Trust alongside 31 other studies that were already underway. A central annual allocation of £384,100 from the Regional Clinical Research Network supports 21 staff including clinicians; research nurses and associated staff; staff in NHS service support (pathology, radiology and pharmacy) and research management staff. Additionally, the Trust received funds through a research grant from the David Hyde Asthma and Allergy Research Centre and our commercial team also receives funds to undertake drug studies on behalf of pharmaceutical firms.

During 2018/19, the Trust recruited 1,253 patients to participate in research projects. This was an increase of nearly 300 patients compared to the year before and played a part in the Trust being nominated for a regional award. Participation in clinical research is not only important for our patients but also for our staff. Through active participation in research, our clinical staff stay up-to-date with the latest possible treatments, network with other research active centres across the world, and develop skills such as data management and disease assessment, which have wider benefits for our patients and service users. All of this improves patient care, provides development for our staff and makes our Trust a more desirable place to work when it comes to recruitment and retention of staff.

Operational performance analysis

The following areas took part in trials over the year:

- asthma & allergy
- cancer
- cardiovascular disease
- children
- dementia & degenerative diseases
- diabetes
- gastroenterology
- orthopaedics
- mental health
- metabolic & endocrine disease
- ear nose and throat
- ophthalmology
- reproductive health & childbirth, respiratory disorders
- stroke
- health service management
- emergency medical cover across the acute hospital

The David Hide Asthma and Allergy Research Centre (DHAARC) remains the most important site for research at The Isle of Wight NHS Trust, typically recruiting more than half the total number of patients. The centre, in collaboration with The University of Southampton, undertakes studies in the field of

paediatric and adult asthma and allergy research and boasts an international reputation for research of this type. DHAARC studies are carried out with other universities in the UK and around the world, including:

- The Jolla, California
- Michigan State University
- University of Memphis
- The University of Manchester
- University of Bristol
- Imperial College London
- University of Oslo
- University of Portsmouth
- University of Colorado Denver School of Medicine
- Children’s Hospital Colorado

Our engagement with clinical research demonstrates our commitment to testing and offering the latest medical treatments and techniques for our patients and service users. In 2019/20, we intend to increase patient participation by opening new trials in other areas, as well as growing the volume of work in those areas in which we have always conducted studies.

Getting to Good

The Trust has improved access to its Early Intervention Psychosis service

The Early Intervention Psychosis (EIP) service has moved to a new, more convenient location close to the centre of Newport town. The new premises in Orchard Street has been improved to ensure the accommodation and environment meets the needs of the people using the EIP service and the staff based there.

Psychosis is a treatable mental health condition that affects the mind and can change the way people think, feel and behave. It can be difficult for people to distinguish between reality and the imagination and it commonly develops in adolescence and early adulthood.

The EIP team help assess, treat and support young people who are in the early stages of a psychotic illness. Anyone between the age of 14 – 65 and are experiencing their first episodes of psychosis can refer themselves to the service, without having to go through a General Practitioner (GP). The new location is convenient for people who want to walk in and have a chat with a member of the team in a safe and comfortable environment.

Isle of Wight NHS Trust's performance against a range of targets for the past four years

| Area | Metric | Target | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|--------------------------|--|---------|---------|---------|---------|---------|---------|---------|
| Unscheduled Care | Emergency care 4 hour standard | 95% | 97.00% | 93.52% | 88.78% | 86.00% | 85.17% | 81.59% |
| | Ambulance – Cat A % < 8 min ***** | 75% | 76.20% | 75.78% | 71.25% | 63.20% | 65.84% | |
| | Ambulance – Cat A % < 19 min ***** | 95% | 96.60% | 96.25% | 94.93% | 91.90% | 89.82% | |
| | Ambulance – Cat 1 Mean Response Time (mm:ss) ***** | 07:00 | | | | | | 10:34 |
| | Ambulance – Cat 2 Mean Response Time (mm:ss) ***** | 18:00 | | | | | | 19:35 |
| | Stroke: % spending 90%+ time on stroke unit | 80% | 91.70% | 91.80% | 86.05% | 84.80% | 86.60% | 84.25% |
| | % of people who have a TIA who are scanned and treated within 24 hours | 60% | 81.50% | 69.13% | 72.48% | 98.90% | 100.00% | 94.12% |
| Planned Care | RTT: % of admitted patients who waited 18 weeks or less | 90% | 91.00% | 85.95% | 58.80% | 57.00% | 57.20% | 48.27% |
| | RTT: % of non-admitted patients who waited 18 weeks or less | 95% | 96.80% | 93.01% | 94.79% | 90.00% | 89.00% | 83.13% |
| | RTT: % of incomplete patients who waited 18 weeks or less* | 92% | 95.80% | 93.98% | 90.95% | 88.00% | 90.00% | 77.03% |
| | Patients waiting more than 6 weeks for diagnostic | <100 pa | 43 | 25 | 53 | 53 | 264 | 1,112 |
| | Symptomatic breast cancer referrals seen <2 weeks*** | 93% | 94% | 92.27% | 97.41% | 96.40% | 97.00% | 93.20% |
| | Cancer patients receiving subsequent chemo/drug <31 days*** | 98% | 99.50% | 100.00% | 99.58% | 99.80% | 99.70% | 100.00% |
| | Cancer patients receiving subsequent surgery <31 days*** | 94% | 99% | 98.37% | 98.24% | 98.00% | 99.30% | 98.60% |
| | Cancer patients treated after screening referral <62 days*** | 90% | 99% | 95.00% | 97.22% | 93.20% | 97.20% | 92.90% |
| | Cancer diagnosis to treatment <31 days*** | 96% | 99% | 99.12% | 99.12% | 99.50% | 99.00% | 99.20% |
| | Cancer urgent referral to treatment <62 days*** | 85% | 94% | 87.09% | 82.96% | 84.20% | 81.00% | 74.10% |
| | Cancer patients seen <14 days after urgent GP referral*** | 93% | 96% | 95.96% | 96.03% | 97.10% | 97.40% | 96.20% |
| Patient safety & Quality | HCAI: Clostridium Difficile (C. Diff .) infection rates | 7 | 7 | 12 | 23 | 12 | 18 | 12 |
| | HCAI: Incidence of MRSA | 0 | 2 | 1 | 3 | 1 | 0 | 0 |
| | Mixed sex accomodation breaches | 0 | 0 | 10 | 59 | 12 | 146 | 148 |
| | Summary Hospital-level Mortality Indicator (SHMI)** | - | 1.12 | 1.06 | 1.003 | 1.015 | 1.097 | 1.015 |
| | VTE risk assessment* | 95% | 88.60% | 98.64% | 99.24% | 99.00% | 99.00% | 98.83% |
| Mental Health Services | CPA – Formal Review within 12 months | 95% | | | | 97% | 98% | 46% |
| | CPA – 7 day follow up | 95% | 95% | 97% | 97% | 95% | 94% | 96% |
| | Crisis resolution home treatment | 95% | 98% | 99% | 95% | 95% | 96% | 89% |
| | % of EIP pathways completed within two weeks | 53% | | | | 81% | 83% | 55% |

Notes to the operational performance table

- * Target introduced in 2012/13
- ** Reflects figures published Oct 12, Apr 15, Jan 16 & Jan 17
- *** Cancer figures for March 2016/17 are pending validation - YTD figure may change slightly
- **** EIP target changed in 18/19 to 53%. Previously it was 50%
- ***** Ambulance Targets changed during 2018/19 and now record a mean response time

The challenges faced across the system have continued to impact on the achievement of key performance targets during the year. Current benchmarked performance is outlined in the table on page 19. The Trust monitors performance through the Board Assurance Committees and in a comprehensive performance report, which is discussed at the monthly Trust Board meetings, held in public.

The Trust has sought external expert opinion over the last 12 months to identify areas of opportunity across the Trust. Of particular note is the System Sustainability Plan which identified the need for a significant rebalancing of non-acute care currently provided in the hospital setting to the community. In addition, we have received support in increasing both operating theatre and outpatient efficiency, and these programmes of work will continue into 2019/20.

The Trust's performance against the four-hour Emergency Care Standard (ECS) did not consistently meet its target. Over the last year, there has been further investment in staffing levels within the Emergency Department (ED) and Medical Assessment Unit (MAU) and support to improve flow and patient experience. This included improvements to the ED layout, the development of Same Day Emergency Care (SDEC) and the relocation of ED minors. The Trust is committed to improving its current operational performance and delivering the ECS, which currently achieves on average 81%. The following improvement actions will contribute to this:

- Continue and develop clinical streaming
- Develop the delivery of (Same Day Emergency Care) SDEC over seven days
- Reduce length of stay (LOS) of patients staying longer than seven days (stranded patients) on wards and reduce the number of bed days occupied by patients with a LOS greater than 21 days, termed super stranded, to less than 10% of current bed stock or less than the benchmarked figure in a comparable Trust
- Reduce delayed transfers of care (DTOCs)
- Continue to recruit to the ED business case

In addition, the Trust is continuing to implement the emergency care data set and now has access to enhanced NHS 111 services including pilot schemes with GPs, pharmacies, mental health services, and the integration of urgent care through the Urgent Care Redesign project within the Co-ordinated Access Programme.

The Trust's performance against Referral to Treatment (RTT) has deteriorated in 2018/19 owing to the reduced elective capacity over an unusually hot summer, as well as the usual winter period, combined with a large increase in referrals. Additional operating capacity is available in theatres and improvements to the configuration of day surgery, combined with improvements to inpatient flow, will allow this to be leveraged. The Trust continues to be committed to treating patients in the most timely and efficient way possible and improvement programmes are aligned to support this.

Non-achievement of the Cancer 62-day target was owing to inconsistent performance in the year on account of complex pathways requiring multiple diagnostic tests both at the Trust and at tertiary providers. The Trust is committed to ensuring all eight waiting time standards for cancer are met, including the 62-day referral to treatment cancer standard, and acknowledges the impact of implementing '10 high impact' actions on being able to achieve this.

Over the last 12 months, the Isle of Wight has been receiving support from the NHS Intensive Support Team (IST), utilising and adapting a range of IT tools to identify where there are opportunities to reduce waiting times. Some of the tools developed in-house have been used as examples of good practice nationally and are currently utilised to diagnose our waiting list issues.

In 2018/19, the Isle of Wight has specifically focussed on:

- Increasing the number of cancer pathway trackers in the cancer pathways team
- Increasing local diagnostic imaging capacity
- Increasing local endoscopy capacity
- Increasing cancer nurse specialist capacity to manage increased referrals and increased activity per patient

In addition, the Trust is currently piloting a new urology cancer pathway, which has been highlighted as an area of innovative good practice by NHS Improvement, and which aims to reduce waiting times in this specialty by up to three weeks for the average patient. The Trust will work towards NHSE/NHSI's recent planning guidance and recommendations for delivering objectives during the next one-to-three years, in particular, implementing national pathways and the new cancer waiting times system ahead of the 28-day Faster Diagnosis Standard, as well as working towards the national bowel screening programme targets.

The Trust continues to deliver on requirements of a number of national targets for mental health. Performance in 18/19 is as follows:

- The target for patients requiring early intervention in psychosis has been challenging at times throughout the year owing to staffing levels within the team, but the end of year performance was above target.
- The processes for seven-day follow-up for patients discharged from in-patient services are regularly reviewed to ensure patient safety and to maintain good performance against this indicator.
- The year-end position regarding the IAPT access target is below the local stretch target of 22%, however we have achieved the national target of 19%. Performance against the recovery target continues to improve and year-end recovery target has been achieved.
- Performance against the Access to Crisis Resolution/Home Treatment targets for patients admitted to inpatient services indicator has been below the required level throughout 18/19. It should be noted that the small number of patients admitted impacts on performance against this indicator i.e. just one unavoidable breach in a month is enough to mean the target is not achieved.

- The indicator regarding waiting times for routine referrals for children and young people with suspected eating disorders was not achieved in 18/19. The Children and Young People with an Eating Disorder (CYP ED) Access and Waiting Time Standard is, that by 2020/21, 95% of CYP (up to the age of 19) referred for assessment or treatment of an eating disorder should receive NICE-approved treatment within one week for urgent cases and four weeks for every other case. Achievement of this indicator will be challenging owing to the low number of referrals, as just one or two breaches in the year results in performance below the 20/21 standard.

Performance for 999 and the Ambulance Service has continued to improve month-on-month since the new computer aided dispatch system was implemented in October 2018. The service has fully reported against the ambulance response programme standards since this date.

- The service has commissioned a capacity modelling report through South Central Ambulance Service, which demonstrates that the service is under capacity in relation to fleet/crews in order to consistently meet the national ambulance response standards.
- Discussions are ongoing with commissioners in relation to the current ambulance contract in order to address the above
- The service is demonstrating a safe level of non-conveyance by community practitioners with low re-attendance rates
- The service audits all long waits and re-attendances, and undertakes mortality reviews on all patients
- The NHS 111 performance demonstrates a continued position of good call handling standards, with improving clinical standards. The overall performance of the NHS 111 service on the island continues to be excellent, with consistently fewer 111 calls, resulting in an ambulance disposition better than the national average.
- A business case has been presented to the Trust Capital Investment Group to deliver the integration and electronic booking portal that will enable the Patient Transport Service to begin reporting against key performance indicators (KPIs).

Financial performance 2018/19

Sustainability

Our vision is to provide high-quality healthcare services in an environmentally sustainable manner. We are taking active steps to improve our energy efficiency, lower our water consumption, and reduce the impact of the waste we generate. We are updating our plans that set out our ambitions for reducing our environmental impact and embedding sustainability principles within the organisation.

Water

The Trust has a comprehensive water management process in place that includes the use of an external contractor to validate and monitor our water usage. When considering new developments, we consider the impact on water consumption and seek to reduce water consumption where we can, by consolidation of the estate and using efficient products and fittings.

Energy

The Trust considers energy usage, the environmental impact and our carbon footprint as a part of day-to-day estate management as well as in strategic planning and new developments. All replacement and new installations include energy efficient systems and fittings, and we seek to reduce our energy usage through estate-related improvements, consolidation of the estate and energy awareness campaigns. In addition, we utilise an external contractor to validate and monitor our energy usage.

Waste and recycling

The Trust has an agreement in place with the Isle of Wight Council, where we share waste management resources and work together to ensure we utilise resources efficiently and provide the most sustainable waste management process. We continue to separate our recyclable waste and run waste awareness campaigns to ensure we maximise the efficient management of our waste. In addition, the Trust has implemented a system that reuses surplus equipment and supplies in order to avoid waste and help drive efficiency.

Outturn delivered (2017/18 figures in brackets)

As reported in the Annual Accounts, the Trust posted a deficit in 2018/19 of £30.102m (£23.25m). This deficit position was an increase against the planned deficit of £12.953m (£18.84m) owing to:

- Additional costs from investments in quality to improve patient experience, as a result of the Trust remaining in quality special measures during 2018/19
- Continued use of temporary agency staff owing to difficulties in recruitment of permanent staff
- Not delivering the full cost improvement programme

Investment in capital expenditure (2017/18 figures in brackets)

The Trust had a Capital Plan of £6.9m (£9.09m) consisting of an initial limit of £6.6m, slippage from 2017/18 of £0.1m and Public Dividend Capital investments in cyber security and pharmacy information systems.

Capital investments during 2018/19 included:

| | |
|----------------------------|-------|
| IM&T systems | £1.3m |
| Equipment RRP | £1.2m |
| Backlog maintenance | £1.1m |
| Ophthalmology unit upgrade | £0.8m |
| Service relocation | £0.8m |
| Paediatric assessment unit | £0.7m |
| Ambulance CAD | £0.5m |
| A&E streaming | £0.2m |
| Others | £0.3m |



Getting to Good

New feedback system enhances analysis of patient care

The Trust has launched a new patient feedback system, offering a more thorough analysis of patients' experience of care.

The new system, built by Membership Engagement Services, enables each Trust service to build its own unique patient experience surveys, with the ability to further analyse results so they can respond to patient needs more effectively.

The old system allowed for just two members of staff to login and access data, but now staff from every department and service will have access to their own dashboard that displays and analyses the information that's relevant to them and enables them to create bespoke, editable reports.

The system also offers a more sophisticated sentiment analysis, detailing the context behind comments and phrases that will enable the Trust to spot trends over time. Staff will also have the ability to create 'You said, we did' reports to track and showcase responses to patient feedback.

The new system, which can also incorporate information from national surveys such as the Adult Inpatient Survey, is in early stages of use across the Trust. The Trust's patient experience team is now working with staff and patients to create a survey template which will be sent to teams to showcase the system's capabilities, before further training and support is offered to allow teams to maximise its potential. Ultimately, the new system will become the Trust's single platform for capturing all patient feedback, as well as the staff Friends and Family Test.

Private healthcare supports public healthcare

The Isle of Wight NHS Trust's Mottistone Suite offers the only private healthcare on the island to patients who have insurance or who choose to self-fund. Outpatient appointments, endoscopies, diagnostics and elective procedures are all available privately. In 2018/19, the Mottistone had a turnover in excess of £1 million. During peak times, the Trust is able to utilise The Mottistone Ward to ensure that NHS operations still go ahead. The latest CQC inspection did not include private practice, however, as result of the inadequate rating, the Isle of Wight NHS Trust has been suspended as a recognised private supplier by three insurance companies. All insurance companies are continuing to honour patient choice and will provide pre-authorisation on request and this suspension will be reviewed following any further CQC inspections.

Pension liabilities

Details of how pension liabilities are treated can be found in Note 10 in the full Accounts and the Remuneration Report.

External auditors' remuneration

We are required to declare any remuneration paid to auditors in respect of any non-audit work undertaken by them. Disclosure is required by regulations made under s94 of the Companies Act 2006. We can confirm that our external auditors have not undertaken non-audit work for the Trust during 2018/19.

Cost allocation and charges for information

The Trust has complied with HM Treasury's guidance on setting charges for information.

Fraud and corruption

The Trust has a robust and effective counter fraud service provided by TIAA Ltd (www.TIAA.co.uk), who were reappointed during the year after a tendering process. This minimises the cost of fraud and corruption and frees up resources for better patient care.

Better payments practice code and prompt payments code

The Trust has signed up to the Better Payments and Practice Code and Prompt Payments Code. Details are included in Note 35 to the full Accounts.

Disclosure to auditors

All current directors have made a statement that – so far as they are aware – there is no relevant material information or third party transactions of which the company's auditors are unaware. All directors have taken steps to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Looking forward

Significant service and recruitment challenges remain in 2019/20. Our Board-approved budget for 2019/20 is a planned deficit of £3.999m, including a £10.5m Cost Improvement Programme. The savings requirement equates to 5% of turnover. The Trust's capital plan for 2019/20 is an expected investment of £6.4m.

The business as a “going concern”

Overall performance

At the end of the 2018/19 financial year, the Trust achieved a pre-audited deficit of £30.102m. For 2018/19, the forecast position was a Board-approved plan of a deficit of £17.149m, although this was revised to £30.102m after month nine. The Trust had a capital investment plan of £6.9m consisting of an initial limit of £6.6m and slippage from 2017/18 of £0.1m. The Trust also received public dividend capital of £0.1m for cyber security and pharmacy IT. The Trust's capital expenditure investment was £6.9m.

Financial planning for future years

The Trust has produced its financial plans for 2019/20, based on its internal budget setting process and framework, and agreed level of contracting income from its commissioners. The Board has approved a financial plan for 2019/20 of £3.999m deficit, with a cost improvement target of £10.5m.

The Trust has concluded the 2019/20 contract negotiations with the Isle of Wight Clinical Commissioning Group for a contract value of £143.7m, and with NHS England for a contract value of £8.6m. Based on an income and expenditure deficit of £3.999m, the normalised EBITDA position is £5.486m surplus for 2019/20.

Cash-flow

The Trust borrowed £30.1m during 2018/19 to support the deficit, bringing total borrowing from Department of Health and Social Care to £67.9m. Deficit funding will also be required for 2019/20 and loan requests for April (£2.7m) and May (£0.7m) have already been approved as part of the cash management process through NHS Improvement.

There is a requirement to commence repayment of the loans in April 2020 as amounts borrowed are repayable three years from the date of borrowing. Interest on loans is expected to be circa £2m in 2019/20.

The Trust's banking is conducted through the Government Banking Service.

Overall conclusion

International Accounting Standard 1 (IAS1) requires the Board to consider which of the following three scenarios is appropriate:

1. The Trust is clearly a going concern and it is appropriate for the accounts to be prepared on the going concern basis.
2. The Trust is a going concern but there are uncertainties regarding future issues which should be disclosed in the accounts to ensure a true and fair view.
3. The Trust is not a going concern and the accounts will need to be prepared on an appropriate alternative basis.

The audit committee considered the going concern concept on 1 May 2019, and recommend to the Board to approve that the 2018/19 accounts are prepared on the basis that the Trust is a going concern but there are uncertainties regarding future issues, which should be disclosed in the accounts to ensure a true and fair view.

Following discussions with the Trust's external auditors, the following has been included in the accounts as Note 1.1.2 Going Concern:

These accounts have been prepared on a going concern basis, as there is no indication that the healthcare and other services will not continue to be provided by the public sector for the foreseeable future and that continuing financial support will be provided by DHSC.

This year the Trust has struggled to meet its financial targets against a backdrop of increased financial pressure across the NHS, and entered Financial Special Measures in March 2019. A Finance Improvement Director was appointed by NHS Improvement in March 2019 to provide additional support in recovering the financial position.

For 2018/19 the Trust has returned a deficit of £30.1m and has achieved £6.8m savings through the Cost Improvement Programme. The DHSC provided deficit funding of £30.1m as revenue support loans in year bringing the total revenue support loan funding to £67.9m at 31 March 2019. Regulatory oversight undertakings have been in operation during the year and the Trust is focused on exiting from Quality Special Measures by 2020.

The Trust's control total for 2019/20 is a deficit of £3.999m, which includes £17.502m of PSF and FRF funding, and is expected to be achieved by the Trust. The plans reflect assumed continued revenue deficit support funding from DHSC for the £3.999m deficit, and this support funding is authorised by DHSC monthly in advance. Deficit support funding of £2.7m for April and £0.7m for May has been provided to the Trust and £0.556m for June has been requested from DHSC.

The Trust has a contract agreement with the Isle of Wight CCG for 2019-20 for a value of £143.7m. The Trust also has in place a contract with NHS England for £8.6m.

The Trust's 2019/20 cash flow forecast is based on the assumptions in the 2019/20 financial plan. The key assumptions underpinning the cash flow are receipt of £3.999m revenue support loan from the DHSC to finance the revenue deficit, and £17.502m of PSF and FRF funding.

The cash flow position is reported to the Performance Committee and the Board monthly and this is based on the Trust's detailed cash flow forecast which is updated daily.

Taking into account all these factors, the assumption that the healthcare and other services will continue to be provided by the public sector for the foreseeable future and that the DHSC will continue to provide financial support, the Board consider the Trust will continue to operate as a going concern. The conditions described above do, however, indicate the existence of material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern.

The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

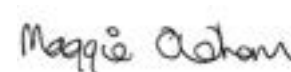
- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- Make judgements and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts

The directors are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board.



Darren Cattell
Chief Financial Officer



Maggie Oldham
Chief Executive Officer

Corporate information

Trust Board structure and operational management arrangements

The Trust Board has undergone some significant change since the date of the CQC inspection in the early part of 2018, building on the changes it had begun to implement following the 2017 report. The CQC commented that:

“We found clear signs of recovery and improvement since our inspection in November 2016 and there was growing momentum. However this recovery was starting from a very low base and, despite some elements of outstanding leadership from the senior team, it was too early for the overall rating to change.”

The Trust Board has continued to evolve over the year and was further strengthened by the introduction of three new Non-Executive Directors (Paul Evans, Phil Berrington, Kemi Adenubi) and substantive appointments of our Executive Directors with Darren Cattell as Director of Finance, Estates, IM&T and Deputy CEO, Alistair Flowerdew as Medical Director, Lesley Stephens as Director of Mental Health & Learning Disabilities and Alice Webster as Director of Nursing, Midwifery, AHPs and Community Services.

A diagram of the composition of the board is available on page 61 of this report and biographies of our Board are available on our website.

During 2018/9, the Trust's operational services changed from being organised as discrete clinical business units to a divisional model focusing on the four key functions of the Trust; Acute, Mental Health & Learning Disabilities, Community, and Ambulance which evolved into the Integrated Urgent & Emergency Care division. The divisions are supported by a range of corporate services.

More information about the Trust's governance arrangements can be found in the Annual Governance Statement, see page 32.

Board committees

The business of the Trust is managed through Board Assurance Committees, which are shown on page 33. Full details of these committees, their membership and terms of reference are available on our website at www.iow.nhs.uk

In accordance with good governance, the Trust has undertaken an annual review of the effectiveness of its structures and, in light of this, will be making further revisions for 2019/20 to continue to strengthen its assurance and build on the work undertaken to date. This will include the introduction of a new Board assurance level committee focussed on human resources and organisational development, supporting our focus on our workforce as a key part of our 'Getting to Good' journey.

Transparency at the Trust – the Register of Interests

Every year, senior staff and Board members are required to declare any interests, particularly those that could conflict with the business of the Trust. Details of these declarations are published on our [website](#).

Being Open and the Duty of Candour

The Trust fully supports the need to be open and transparent in line with national guidance and the Duty of Candour placed on organisations and staff.

During the year, the Trust has continued to implement the Being Open and Duty of Candour Policy training to ensure that staff have the knowledge and are supported to apply the duty. During the latter part of the year, further improvements have been made to the systems and process for reporting and monitoring compliance with Duty of Candour to ensure we are fully complying with our commitment to be open and transparent.

Slavery and human trafficking

At the Isle of Wight NHS Trust, we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. This statement sets out actions taken by the Trust to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

Our approach

We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management are expected to act upon them in accordance with our policies and procedures.

Due Diligence

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Undertake appropriate pre-employment checks on directly employed staff, and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff.
- Implement a range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These include provision of fair pay rates, fair terms of conditions of employment and access to training and development opportunities.
- Consult and negotiate with trade unions on proposed changes to employment, work organisation and contractual relations.
- Purchase most of our products from UK or EU based firms, who may also be required to comply with the requirements of the UK Modern Slavery Act (2015) or similar legislation in other EU states.

- Purchase a significant number of products through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour.
- Require all suppliers to comply with the provisions of the UK Modern Slavery Act (2015), through our purchase orders and tender specifications.
- Uphold professional codes of conduct and practice relating to procurement and supply.

Build long-standing relationships with suppliers, where possible and consistent with the public contracts regulations.

Training

Advice and training about modern slavery and human trafficking is available to staff through our Safeguarding Children and Adults training, our safeguarding policies and procedures and our safeguarding leads.

Membership

The Trust is a key part of the island community and we run programmes of engagement to strengthen our relationships with local groups, our stakeholders and individuals.

The Trust remains committed to being a 'membership organisation' and currently has circa 5,200 subscribed 'public members'. These are members of the public, who have an interest in, or want to make a difference to healthcare on the Island and, since implementation of the Gov Delivery system, they now have full control over their subscription preferences. This ensures that they do not miss out on receiving information and invitations about the services that are of greatest interest to them.

Activities during this year included five 'Medicine for Members' meetings, with each one being very well attended. These events inform members what is happening across the breadth of the Trust giving them the opportunity to help shape our future plans, and quiz the clinicians and senior team in a friendly, open forum. This year, members have also voted for what they think the Trust's main priorities should be, and also attended a workshop to set the clinical standards for the Trust.

Patient Council

Our Patient Council meets on a regular basis to discuss developments and plans that could impact on patients and the wider public. There are currently 19 patient representatives who help provide patients' perspectives and address matters as identified as important. Members of the council are involved in shaping strategies and new initiatives within the Trust and also provide regular representation to various Trust committees and the Trust Board meeting.

The council members are currently in the process of re-electing a new chair to start at April's meeting after their recent chair had to step down after 18 months in the position. The council is also in the process of starting a recruitment campaign to seek a further six members to join them, making the total number of members to 25.

The Patient Council now has a logo in order to help give it a greater identity within the local community. It has made itself more visible via social media and is requesting that members of the public share their experience of Trust services.

The Patient Council has been supportive and involved with discussions on Cross-Solent travel and has continued to raise concerns brought to its attention about car parking at St Mary's Hospital site.

Quality governance and nursing services

Quality governance is overseen by the Director of Quality Governance, Suzanne Rostron. The corporate quality services provided include:

- Patient safety and experience
- Complaints
- Patient Advice and Liaison Service (PALS)
- Chaplaincy
- Risk and litigation
- Healing arts
- Main reception
- Health, safety and security
- Quality improvement

The team is also responsible for:

- Quality strategy and contract
- Quality account
- Care Quality Commission liaison
- Serious incidents
- Quality strategy and priorities
- Clinical governance
- Friends and family test
- Duty of Candour
- Patient Safety Alerts

Principles for Remedy

The Trust supports the Principles for Remedy published by the Parliamentary and Health Service Ombudsman (PHSO) in May 2010 and implements these principles as part of the Trust's complaints handling procedure. We regularly review our complaints handling processes to ensure we are working in line with the 'user-led vision for raising concerns and complaints'. Learning from patient experience is one of the Trust's quality strategy domains, which has key indicators to achieve in relation to managing and learning from complaints and has been a key focus for the Trust this year.

Information governance

During 2018/19, there were nine level two information governance incidents that were reported to the Information Commissioners Office. More details of these can be found in the Annual Governance Statement on page 52.

Working with others

The Trust is proud of its relationship with regional organisations, such as Healthwatch Isle of Wight. We have established a two-way dialogue whereby feedback from Healthwatch is passed on to our Board, who use it in shaping and improving our services.

Our relationships with the local authority and CCG grow ever stronger, largely thanks to our collaboration on the Isle of Wight Health and Care Sustainability Plan. The Trust is represented at the Council's Health and Adult Social Care Scrutiny Sub Committee, on the Health and Wellbeing Board Executive Committee and we provide various briefings for councillors and officers.

Emergency preparedness, resilience and response

The Trust now has a full emergency preparedness, resilience and response team, with the Head of EPRR commencing working for the Trust on 3 December 2018 and the Ambulance Service Emergency Planning & Business Continuity Lead in January 2019.

Until this time, in order to address the areas requiring improvement and to support changes in staffing within the Trust's EPRR Team, a system of closer working with the Isle of Wight Council commenced in April 2018, along with interim support being provided by the University of Southampton Hospital Trust EPRR Team from mid-August. The Isle of Wight Council's Resilience Manager ensured that an appropriate level of support and guidance was in place with the Council's resilience co-ordinators providing support to emergency planning and business continuity through a service level agreement (SLA) funded by the Trust. The SLA will continue into 2019 with two days per week for business continuity support and one day per week to support training and exercising.



The council team also provided support to the ambulance service in respect of event planning and the refining of mass casualty arrangements for the events season. The annual NHS England core standards assurance process and the National Ambulance Resilience Unit assessment again identified numerous areas for improvement. However, significant progress has been made with the Trust Emergency Preparedness, Resilience and Response Policy being updated and agreed, key plans reviewed, updated and exercised, training provided for the executive team and senior managers and a review of all business continuity plans. The Head of EPRR, with the Trust's Accountable Emergency Officer, has ensured the Trust was prepared for any impact of the EU Exit following NHS England and Department of Health and Social Care guidance.

Health, safety and security

The Trust has an excellent health and safety record and, as a responsible employer, we encourage staff to report any incidents as part of a healthy, open culture. We have a comprehensive policy covering health, safety and security, which is available on request.

In 2018/19, eight reports were submitted to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. This compares with seven reports last year, 13 reports in 2016/17, 10 reports in 2015/16 and 11 reports in 2014/15.

There were 40 manual handling incidents (such as strains and sprains), compared with 23 in 2017/18, 30 incidents in 2016/17 and 46 incidents in 2014/15.

We continue to take a zero tolerance approach towards violence and abuse directed at staff, and will take legal action against those who are criminally responsible for their actions. During the year:

- There were 293 physical assaults on staff (189 in 2017/18), which includes 20 assaults that were criminal acts and dealt with by the police. Clinically challenging behaviours are a major contributor to the increase of assaults.
- There were 228 (374 in 2017/18) reports of verbal abuse. Owing to conflict resolution training, staff are more likely to report these incidents as there are more support mechanisms in place to safely manage these situations, which has seen the number of reports fall 39% on the previous year.
- Security was called 428 times to assist the wards with situations such as violence and aggression, verbal altercations causing alarm and distress and missing patients.

One of the major threats to healthcare is the outbreak of fire in a building and the Trust works hard to prevent fire and train for an outbreak. Fire safety management is a crucial element within a modern healthcare setting. Good fire safety management will help the Trust to meet set objectives (Quality, Innovation, Productivity, Prevention, Reform) and achieve the critical success factors in two key areas, Quality (Patient Safety, etc.) and Productivity (Develop the Estate, etc.).

Annual Governance Statement 2018/19

1. INTRODUCTION

1.1 I, Maggie Oldham, have been Chief Executive of the Trust throughout the financial year of 2018/19.

2. SCOPE OF RESPONSIBILITY

2.1 As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

3. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

3.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

3.2 The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Isle of Wight NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Isle of Wight NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

4. CAPACITY TO HANDLE RISK

4.1 REGULATORS

4.1.1 In June 2018 the Care Quality Commission (CQC) reported their findings of the investigations into the Trust which took place in January and February 2018, and determined overall that the Trust was inadequate, which included an inadequate assessment for Well Led. The Trust was placed in to special measures by NHS Improvement in April 2017.

4.1.2 CQC carried out a focused inspection in the emergency department at the hospital in January 2019, as part of a programme to assess safety during the winter period. Following the inspection, the CQC issued a Warning Notice requiring the Trust to take immediate action to address concerns about the safety and quality of patients' care in surgery on the basis that at times care and treatment was not always provided in a way that reduced risks to patients. Work has been undertaken since the visit to address the three areas of concern raised.

4.1.3 During the course of 2018/19 improvements regarding well led, including governance, have been made to address the concerns raised by CQC. This has included the strengthening of the Board with a number of new Non-Executive Director and Executive Director appointments, underpinned by a maturing leadership structure and increased implementation of the Trust governance framework with risk management systems and processes embedded.

4.2 WELL LED REVIEW

4.2.1 In 2017/18 the Trust and NHS Improvement jointly commissioned a review of Board leadership, performance and effectiveness. This culminated in a final report that was considered and accepted by the Board in January 2018 which identified significant findings

grouped under the following headings: vision, strategy, culture, Board leadership, executive leadership, Clinical Business Units (CBUs), governance (including risk management), external relationships, engagement with staff and leadership development.

4.2.2 Through 2018/19 the Trust has worked to address the findings of the final report through a range of measures including:

- the development of an Island-wide Plan with the local Council and CCG – encompassing a range of additional external partners, alongside aligned internal strategic development of Divisions (replacing the previous CBU structure),
- The introduction of a culture and leadership programme with a number of supporting strategies and metrics including the use of a culture dashboard to bring together key metrics.
- Governance developments within the Divisional structures have been supported and embedded with internal assessments carried out of effectiveness and the introduction of a Risk Management Strategy from June 2018 and an assessment of risk

maturity undertaken by Internal Audit in Quarter Four of the year providing an assessment of 'risk defined'.

- Development programmes for ward teams, middle leaders, senior leaders, doctors, targeted areas of focus, and the Executive have been implemented during the year.

4.2.3 During 2018/19 the Board has completed self-assessments against the NHSI Well Led Framework and CQC Key Lines of Enquiry and are implementing ongoing plans to address areas where we will make further improvements. Executive Director leads have been identified for each improvement area and proposals for future progress in this area were published at the Board in May 2019 including a new Board Development programme and communications approach.

4.3 BOARD GOVERNANCE

4.3.1 The Board agreed revised Board governance arrangements in December 2017 which became effective from January 2018, with minor revisions in June 2018. This included a new Committee structure as follows:



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| 4.3.2 | 4.3.2 A full review of the Committee structure commenced in March 2019 to consider the effectiveness of each aspect of the governance model and this will lead to revisions being implemented following discussions with each of the Committees and Board during the course of quarter one in 2019/20. These revisions have been published through the Trust Board in May 2019 and are subject to ongoing development to support the effective operation of the Trust governance arrangements, including through the establishment of a Human Resources and Organisational Development Committee. | | considering strategic risks in relation to compliance with regulatory standards and for receiving reports from the Operational Risk Sub-Committee fundamentally regarding corporate risks. |
| | | 4.4.6 | The Audit Committee has responsibility for overseeing appropriate processes and reporting mechanisms are in place for the Board Assurance Framework and risk management. Assurance is received by the Committee through Executive Director reporting, triangulated through internal audit reports. |
| 4.4 | STRATEGIC, CORPORATE AND OPERATIONAL RISK MANAGEMENT | 4.4.7 | The Trust Leadership Committee is an Executive led Committee of the Board and receives updates from each Division including areas of concern and risk to each area. These reports are developed through strengthened governance arrangements with Divisional Quality and Performance Committees reporting into Divisional Boards, to ensure the key escalations are identified in a consistent and effective manner. |
| 4.4.1 | Whilst the Board has overall accountability for ensuring a robust risk management strategy and that an underpinning risk management policy are agreed, implemented and adhered to, each of the Board's Committees has specific delegated risk management responsibilities. | | |
| 4.4.2 | The terms of reference for each Committee were refreshed and agreed by the Board in June 2018, and include risk management responsibilities of agreeing strategic risks for each strategic objective and their associated inherent, actual and target risk scores, considering the risk appetite, receiving assurance from Executive Directors as to the plans for enhancing controls to mitigate each risk and assessing how corporate risks may impact upon each strategic risk. | 4.4.8 | The Board leads sustained improvement in risk management and has been supported through a specific Board Seminar session regarding risk management, which included the agreement of strategic objectives for 2018/19 and consideration of the strategic risks against each objective. A further session to review the strategic objectives and risks for 2019/20 has taken place in May 2019. |
| 4.4.3 | The Performance Committee has responsibility for considering strategic risks in relation to operational delivery, workforce, finance and enabling support services. | 4.4.9 | Executive Directors are responsible for overseeing the implementation of the Risk Management Strategy and compliance with the risk management policy. This forms the specific responsibility of the Director of Quality Governance who oversees the delivery of the milestones within the Risk Management Strategy across the organisation as reported to the Assurance Risk and Compliance Committee. |
| 4.4.4 | The Quality Committee has responsibility for considering strategic risks in relation to quality, including patient safety, clinical outcomes and patient experience. | 4.4.10 | The Operational Risk Sub-Committee meets monthly and receives reports from all areas of the Trust on risk management; providing a forum to ensure consistent |
| 4.4.5 | The Assurance, Risk and Compliance Committee has responsibility for | | |

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| | application of the policy and strategy and reviewing medium and high rated risks across the Trust. | | |
| 4.4.11 | The Assurance, Risk and Compliance Committee receives reports from the Operational Risk Sub-Committee regarding assurances as to the appropriate management of the corporate risks. Considerable progress has been made in developing the risk maturity of the Trust over the previous twelve months, evidenced by the Quarter Four review by Internal Audit providing a rating of 'risk defined' with a plan to continue progress within 2019/20. | | |
| 5. | THE RISK AND CONTROL FRAMEWORK | | |
| 5.1 | I am assured that risk management processes are continuing to be increasingly embedded within the Trust and incident reporting is openly and actively encouraged to ensure a culture of continuous improvement and learning. I am also assured that there are appropriate deterrents in place concerning fraud and corruption. The organisation understands that successful risk management requires participation, commitment and collaboration from all staff. | | |
| 5.2 | The Trust's approach to risk management encompasses the breadth of the organisation by considering financial, organisational, reputational and project risks, both clinical and non-clinical. This is achieved through: <ul style="list-style-type: none"> • an appropriate framework; delegating authority, seeking competent advice and assurance • a risk culture which includes an agreed risk appetite • the integration of risk management into all strategic and operational activities • the identification and analysis, active management, monitoring and reporting of risk across the Trust • the appropriate and timely escalation of risks | | |
| | | 5.3 | Equality impact assessments are carried out to assess the impact of the Trust's decisions and design of services as part of the Trust's legal duty under the Equality Act 2010 – the Trust also use assessments in the development of policies and in consideration of cost improvement plans, and Quality Impact Assessments form part of all change programmes. |
| | | 5.4 | Risks which are rated as having an overall score of 15 or above, in accordance with our Risk Management Strategy and Risk Management Policy, are reviewed at the Trust Leadership Committee on a monthly basis. The Trust has identified a range of material risks, which are currently being mitigated, whose impact could have a direct bearing on national NHS requirements and constitutional targets, CQC registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective. |

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| 5.5 | Key risks at the end of 2018/19 are reflected in the Board Assurance Framework, paragraph 5.10 and included: | within the organisation and identified ways in which additional evidence can be recorded in relation to the assessment of outcomes from risk management which will be reported through the Trust governance structures. |
| 5.5.1 | Workforce; including the challenges of recruiting substantively to a number of areas, and the management of risks associated with the use of locum staffing as a mitigation process, and also the need to develop and retain our staff to support the delivery of effective, good quality care. | |
| 5.5.2 | Use of resources and financial management including achieving the in-year financial plan, planning for future sustainability, delivery of cost improvement programmes, cashflow and receipt of contractual income. | |
| 5.5.3 | Information management and technology developments in order to provide a clear and coherent direction for future works to support the Trust improvement journey. | |
| 5.5.4 | Standards of care and the quality of service delivery; ensuring that our services are able to respond effectively, safely and deliver high quality services to our patients with particular challenges noted in achieving certain acute constitutional targets and recognising the improvement journey underway within mental health services. | |
| 5.6 | Many of the key risks included within the Corporate Risk Register and Board Assurance Framework will continue into 2019/20 and will be presented to the Board for active consideration of the management processes in place. All such material risks have action plans in place which are reviewed by the Executive to ensure effective mitigations are in operation. Management of risks is undertaken in accordance with the processes outlined below which support the Board Assurance Framework that provides a holistic view of the risks to the Trust achieving its strategic objectives. This is shared through the Trust Board on a quarterly basis. During 2018/19 the Trust has undertaken a risk maturity assessment which has confirmed the improving approach to risk management | |
| 5.7 RISK MANAGEMENT STRATEGY | | |
| 5.7.1 | The Risk Management Strategy was formally approved in June 2018 with the Risk Management Policy approved in May 2018. The Strategy sets out the strategic direction for risk management for the Trust for the next three years. It has been developed to comply with legal and statutory requirements, assist in compliance with national standards, promotes proactive risk management and to improve the safety and quality of patient care. | |
| 5.7.2 | In March 2019 the assessment of the first year of the strategy demonstrated that all key milestones had been achieved by the end of the financial year and milestones have been proposed and agreed for 2019/20. | |
| 5.7.3 | The Strategy states that risks are managed at two levels; strategic risks and operational risks. | |
| | | <u>Strategic risks</u> can be considered as those business risks that, if realised, would fundamentally affect the way in which the organisation exists or conducts its business. These risks may have a detrimental effect on the Trust's Annual Business Plan and thus achievement of its key business objectives. This risk realisation could lead to material failure, loss or lost opportunity. Strategic risks are detailed in the Trust's Board Assurance Framework (BAF) and mapped against the Trust's strategic aims. Each of the Board Committees is responsible for managing the strategic risks aligned to them, with oversight at the Assurance Risk and Compliance Committee and ownership at Trust Board level. |

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| | <u>Operational risks</u> can be considered as the risks associated with the key business processes at specialty and clinical business unit level. The issues arising from these will be considered at specialty and clinical business unit level in the first instance, and then escalated to the Operational Risk Sub-Committee and the Assurance Risk and Compliance Committee if required. This approach ensures effective use of key business processes, streamlining information and risks towards the Trusts Strategic aims. | 5.7.7 | In order to succeed, risk management must be embedded at all levels within the Trust. To this end, the following components are critical: <ul style="list-style-type: none"> • Clear and effective governance arrangements • Strong, respected and impactful leadership with accountability • Explicit strategic objectives • Appropriate resource allocation • Integrated planning arrangements • Effective stakeholder involvement • Education and training strategies • Recognising the value of innovation that all staff can contribute to the overall management of risk • A system of risk identification, recording and action planning (Risk Register) • Learning lessons and changing practice both within the divisions / health groups and organisation wide • Sharing lessons to learn with the wider health community • Promotion of a fair and open culture |
| 5.7.4 | The Strategy expresses that an awareness of, and responsibility for, risk issues must be linked explicitly to key objectives in order to build a sustainable risk management culture. There must be delegated responsibility for risks at every level in the organisation. This is crucial to embedding risk management into the organisation and its culture, with risk management seen as an intrinsic part of the way the organisation works. | | |
| 5.7.5 | The Trust is committed to the management of risk in order to: <ul style="list-style-type: none"> • Monitor continuously and seek to improve the quality of care provided in partnership with patients, carers, staff and the public. • Provide a safe environment for the benefit of patients, staff and visitors by reducing and, where possible, eliminating the risk of loss/harm. • Protect its assets and reputation. | 5.7.8 | Risk Management Strategy priorities are: <ul style="list-style-type: none"> • To ensure that risks that could prevent objectives being achieved are proactively identified, quantified and managed to an acceptable level and in doing so provide a robust risk management framework with appropriate reporting arrangements and individual responsibilities clearly identified. • For all strategic risks to be managed in line with the Trust Board's risk appetite. • To improve organisational risk maturity, at all levels of the Trust. |
| 5.7.6 | The Trust is committed to mitigating those risks within its control and preparing contingencies for risks beyond its control. As the Trust seeks to manage risks according to the appetite for those risks, it recognises the need to balance the costs and benefits of measures to reduce risk levels. | 5.7.9 | The risk maturity of the organisation continues to develop and has been rated as 'risk defined' by our Internal Audit assessment at the end of the financial year. As part of the reporting of the Board Assurance Framework risk appetite has been considered and included for each strategic objective. |

5.8 RISK MANAGEMENT POLICY

A refreshed Risk Management Strategy was introduced in May 2018 which clearly sets out the expectations and requirements of individuals and meetings through the governance structure at each level within the Trust regarding the management of risk. It includes a number of useful templates as appendices to support the practical implementation of the Policy.

- 5.8.1 The Policy emphasises that all staff have a responsibility for risk management; however, the following provides an overview of those with specific responsibilities to ensure the implementation of the Policy.
- 5.8.2 Chief Executive is responsible for:
- reviewing the strategic objectives of the Trust with the Board
 - ensuring that the Trust has a Risk Management Policy in place and that it is delivered
- 5.8.3 Executive Directors are responsible for:
- ensuring delivery of the strategic objectives
 - identification, control, monitoring and reporting of the risks which may threaten achievement of strategic objectives
 - maintaining accurate and up to date risk registers, relevant to their objectives and report through the Board Assurance Framework
- 5.8.4 Quality Governance Department is responsible for:
- development and review of the Risk Management Policy
 - provision of education, support and expertise in relation to Risk Management
 - provision of education and training on the Risk Management Policy
 - provision of training of Datix Risk Management system
 - facilitating the reporting of appropriate risks to the Board, Committees and Operational Risk Sub-Committee

- facilitating the provision of a Board Assurance Framework to the Board and Committees
- monitoring and reporting compliance with the Risk Management Policy
- facilitating the reporting of appropriate risks to specialist corporate groups

- 5.8.5 Clinical Directors, Heads of Operations and Heads of Nursing and Quality (or equivalent for non-clinical business units) are responsible for:
- leading and overseeing implementation of the Risk Management Policy at business unit Level which includes the effective identification, control, monitoring and reporting of the risks which may threaten achievement of business unit objectives
 - facilitating the reporting and where necessary, escalation of appropriate risks to the Operational Risk Sub-Committee from the business unit
 - maintaining accurate and up to date risk registers, relevant to their business unit / service objectives
- 5.8.6 Quality Managers (or equivalent for non-clinical areas) are responsible for:
- facilitating implementation of the Risk Management Policy at business unit Level which includes the effective identification, control, monitoring and reporting of the risks which may threaten achievement of business unit objectives, in accordance with the procedure set out within this policy
 - monitoring and reporting compliance with the Risk Management Policy at business unit level, as directed by the Quality Governance Department
- 5.8.7 'Risk Owners' including all Departmental / Ward / Service Managers are responsible for:
- identification, assessment, put in place control measures to reduce risk, monitoring and reporting of the risks which may threaten achievement of business unit objectives, in accordance with the procedure set out within this policy

- use the outputs of the risk assessment process identified within the Health and Safety Policy to support the determination of the identification of risks using the four levels of assessment
- maintaining accurate and up to date risk registers, relevant to business unit objectives

- 5.8.8 Chairs of Specialist Sub-Committees (e.g. Health & Safety Sub-Committee) are responsible for:
- identification, management and oversight of risks relevant to their specialist subject, ensuring appropriate action is taken
 - reporting to the relevant Committee
 - reporting, where appropriate, to the Operational Risk Sub-Committee
- 5.8.9 Chairs of Specialist Groups (e.g. Infection Prevention Control Group) are responsible for:
- identification, management and oversight of risks relevant to their specialist subject, ensuring appropriate action is taken
 - reporting to the relevant Sub-Committee
- 5.9 **QUALITY GOVERNANCE STANDARDS AND STRUCTURES FRAMEWORK**
- 5.9.1 In 2018 the Trust produced a framework, "Quality Governance Standards and Structures", detailing:
- An understanding of what Quality Governance is
 - What is expected by the Trust at various levels of the organisation
 - The roles of key individuals in supporting the governance process
 - Supporting infrastructure, including information sources and template documents

- 5.9.2 The Framework set out the principles that our patients deserve and expect the very best care and it enables all our staff throughout the organisation to work to the same standards and ethos. We need to check that we are providing excellent

care to ensure that our patients are safe and well looked after. We must therefore have transparent systems in place to demonstrate the quality of care that we give. We will achieve this by:

- Asking questions to fully understand the quality of care we are providing
- Ensuring that we constantly strive to not only maintain but improve quality
- Evidencing what we are achieving
- Maintaining clinically effective, caring and responsive care at every contact

- 5.9.3 An overarching objective of the Trusts governance arrangements is that they should enable prompt action to be taken at the correct level to ensure that our patients are kept safe; whilst ensuring that their experience in our care and the outcomes of their treatment are maximised. There is a need to provide robust assurance in terms of safety, patient experience and clinical practice at all levels; demonstrating that lessons have been learned and improvements made without delay. It is therefore essential that governance structures at all levels interject to facilitate effective escalation of issues, and the communication of changes and lessons learned is seamless.

- 5.9.4 In order to deliver these principles and objectives the Trust initiated a new model of governance in 2018 which combines informal weekly meetings focused on prompt action, with formal monthly / bi-monthly or quarterly meetings focused on learning and improvement, and on obtaining assurance. To ensure that the different meetings work as part of one, coherent system, all meetings are required to escalate key matters to the next level, and to communicate lessons to be learned down throughout the organisation to all relevant staff groups.

- 5.9.5 Every member of staff throughout the organisation has a responsibility to ensure that the Trust provides safe, high quality care. Quality governance structures will only work effectively if each individual takes responsibility for their contribution.

5.9.6 It is important that all those involved in quality governance across the trust create a culture of personal responsibility for commitment to safety and quality; and ensure compliance with the policies and procedures in order for the Trust to meet the required standards for our patients.

5.9.7 The requirements set out below have been agreed to provide a coherent 'operating system' for quality governance in the Trust, and to set out minimum standards. They are designed to minimise bureaucracy and are not in any way intended to inhibit clinical leadership from developing approaches to governance, using these structures, which best engage their teams and meet their specific needs.

| Level | Meeting | Purpose | Membership |
|-----------|--|---|---|
| Board | Quality Committee | Seeks assurance, on behalf of the Board, on Quality (safety, effectiveness and experience), achievement of CQUINs, the delivery of the Quality Strategy and the delivery of the OD Strategy. | Chair Non-Exec Directors CEO Exec Directors |
| Board | Performance Committee | Seeks assurance, on behalf of the Board, on all aspects of operational, workforce and financial delivery. | Chair Non-Exec Directors CEO Exec Directors |
| Board | Assurance, Risk and Compliance Committee | Seeks assurance, on behalf of the Board, on the management of risk, alignment of the BAF with corporate and operational risk registers, external visits and compliance with legislation, including CQC. | Chair Non-Exec Directors CEO Exec Directors |
| Board | Audit Committee | Seeks assurance, on behalf of the Board, on all matters of internal control and overseeing the process of risk management. | Chair Non-Executive Directors |
| Board | Mental Health Committee | Ensures that all requirements of the Mental Health Act are complied with. | Non-Exec Directors Exec Directors |
| Board | Nominations and Remuneration Committee | Sets terms and conditions of office for Executive Directors and monitors performance. | Chairman Non-Executive Directors |
| Board | Charitable Funds Committee | The Trust was appointed as Corporate Trustee of the Charitable Funds and the Committee makes and monitors arrangements for the control and management of the charitable funds and reports to the Corporate Trustee. | Non-Executive Directors Director of Finance Medical Director Director of Nursing |
| Executive | Patient Safety Sub-Committee | Executive oversight of the investigation and learning from incidents, claims and inquests, implementation of safety alerts and progress against the Safety Domain priorities of the Quality Strategy. | Director of Nursing (Chair) Director of Quality (Vice Chair) Medical Director Division senior representation |

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| Executive | Patient Experience Sub-Committee | Executive oversight of investigation and learning from complaints, the Friends and Family Test, patient surveys, PALs and of progress under the Experience Domain priorities of the Quality Strategy. | Director of Quality Governance (Chair) Deputy Director of Nursing (Vice Chair) Division senior representation |
| Executive | Clinical Effectiveness Sub-Committee | Executive oversight of clinical effectiveness including delivery of the clinical audit forward plan, national audit participation, findings and actions, NICE compliance, peer reviews, clinical outcomes, benchmarking, morbidity and mortality and progress against the Effectiveness Domain in the Quality Strategy. | Medical Director (Chair) Associate Director – Clinical Effectiveness (Vice Chair) Director of Quality Governance Division senior representation |
| Executive | Operational Risk Sub-Committee | Executive oversight of operational risk management, including Division and Directorate risk registers of risks >12, external agency visits and overview of policy management. | Director of Quality Governance (Chair) Board Secretary (Vice Chair) Division senior representation Corporate Functions representatives |
| Executive | Health Safety & Security Sub-Committee | Executive oversight of health, safety and security legal requirements including the risks to health & safety and security. | Director of Quality Governance Head of Health & Safety and Security Division senior representation Corporate Functions representatives |
| Executive | Policy Manub-Committee | Executive approval of the majority of at Trust Board (e.g. Standing Financial the Trust policies, with the exception of those requiring approval instructions, Scheme of Delegation). | Board Secretary (Chair) CBU senior representation Corporate Functions representatives |
| Executive | Information Governance Sub-Committee | Executive oversight of information governance legal, statutory and mandatory requirements, including the risks to information governance and data security and the control of those risks. | Senior Information Responsible Officer (SIRO) (Chair) Division senior representation Corporate Functions representatives |

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|------------------------------|--|--|--|
| Executive | Divisional Boards x 4 | Executive oversight of functioning within the Divisions. | Executive Director of: <ul style="list-style-type: none"> • Acute • Community • Mental Health & Learning Disabilities • Ambulance/ IUEC Senior Divisional representation Service leads Corporate Functions representatives |
| Division | Quality Committee | Division oversight of clinical performance (mortality, audit data, benchmarking), service level patient feedback, ward audits, service level risk registers, complaints, incidents. | Senior Division representation (Chair) Matrons / Clinical leads Quality Manager Representation from corporate quality team |
| Specialty / service | To be determined locally (e.g. Ambulance CQEG) | To look at clinical performance (mortality, audit data, benchmarking), service level patient feedback, audits, service level risk register, complaints, incidents and lessons learned. | Service Lead (Chair) Complaints/ claims/incident/risk representation Ward/locality/team leaders |
| Ward / team | Ward / Team meetings | To look at clinical performance (mortality, audit data, benchmarking), service level patient feedback, audits, service level risk register, complaints, incidents and lessons learned. | Service Lead (Chair) Complaints/claims/ incident/risk representation Ward/locality/team leaders |
| Ward/ locality/ team leaders | Ward / Team meetings | The expectation is that wards/teams will share knowledge and experience; particularly good practice and lessons learned | Team leader Team members |
| Corporate – lead | SI meeting | Exec overview of incidents reported to inform SI declarations, monitoring of DoC and learning from incidents | Director of Nursing / Medical Director or Director of Quality Governance Deputy Director of Nursing Patient Safety Lead/SI Co-ordinator Service representatives from clinical services |
| Quality Team | Triangulation meeting | Weekly overview of complex cases, triangulation of information, action tracking and monthly themes/trends. | Claims, inquests, complaints, PALS, incidents, risk and clinical effectiveness representatives. |

| | | | |
|--------|---|---------------------------------------|---|
| 5.9.8 | Key roles and responsibilities are described within the Framework as follows. | 5.9.12 | The Quality Governance Department is responsible for the systems and processes required to support the delivery of quality governance. The Department must evaluate continuously the efficacy of risk management and assurance systems and committee communication to ensure the Trust Board and senior managers receive information and intelligence they require. Liaising with all inspectorates also falls into the remit of this department. The department will implement systems and processes to ensure the Trust can demonstrate compliance with the Care Quality Commission Key Lines of Enquiry for Quality and Safety on a continuous basis. Any gaps in assurance should be identified and escalated in a timely manner. |
| 5.9.9 | The Trust Board is responsible for defining and leading the strategies that are in place to support the delivery of the Trust's strategic direction, and to ensure that assurance is received that objectives are being delivered. The Trust Board is responsible for: <ul style="list-style-type: none"> • Defining the priorities for quality improvement and setting realistic, measurable goals; • Identifying the risks to quality and the steps needed to mitigate these risks; and • Setting out the vision for quality in a way that engages staff, patients and the local community • Managing risks to the achievement of strategic objectives using the Board Assurance Framework • Seeking assurance from the Board Committees | 5.9.13 | The Information Department is responsible for supporting quality governance through the provision of timely and accurate performance data. |
| 5.9.10 | The Chief Executive has overall accountability for all quality governance and assurance arrangements within the Trust. The Director of Nursing has Executive responsibility for Patient Safety. The Medical Director has Executive responsibility for Clinical Effectiveness. The Director of Quality Governance (DQG) is the 'nominated individual' responsible for continuous compliance with the fundamental standards. As such, the DQG is responsible for the effectiveness of this framework and has Executive responsibility for Patient Experience. All Executive Directors are responsible for supporting the Trust Board in the maintaining high quality governance standards, identifying, assessing and managing risks in their portfolio areas. | 5.9.14 | Each Divisional Director is the accountable officer within their Division. They are accountable to Chief Executive and Trust Board for the delivery of quality governance within their Division and should ensure robust systems and processes are in place to support this. |
| 5.9.11 | The Non-Executive Directors provide an independent voice at the Trust Board. Their role is to scrutinise and challenge all aspects of Trust business including Quality Governance. In addition to this collective role, all Non-Executive Directors are members and/or Chairs of Board Committees. | 5.10 BOARD ASSURANCE FRAMEWORK | |
| | | 5.10.1 | The Trust set out its refreshed strategic objectives and the strategic risks relating to these strategic objectives for 2018/19 at a Board Seminar session in June 2018. |
| | | 5.10.2 | This was presented to Board in July 2018 including the Quarter One position for formal agreement as to the strategic risks, associated inherent, actual and target risk scores for the financial year, controls in place, gaps in controls and actions required over the remaining three quarters of 2018/19 to mitigate those risks. Since that point reports have been taken to all meetings of the Audit Committee, Assurance Risk and Compliance Committee, and on a quarterly basis to the Performance Committee, Quality Committee, and Board. |

5.10.3 In April 2019 the respective assurance committees received an end of year summary of the Board Assurance Framework position, noting the areas where risks had been effectively mitigated to reduce the level of risk (likelihood or impact) to the Trust strategic objectives, and has been submitted for Board approval in May 2019.

5.10.4 The following table provides a summary of risk scores for each of the five strategic objectives and underpinning strategic risks as at quarter 4 for 2018/19 and being reported through Committees in April 2019 and to Board in May 2019:

| RISK APPETITE | STRATEGIC OBJECTIVES AND STRATEGIC RISKS | INHERENT RISK SCORE | | | RISK SCORE AT Q4 | | | PROPOSED RISK SCORE | | | TARGET RISK SCORE | | | LEAD COMMITTEE | EXECUTIVE LEAD | POSITION |
|--|--|---------------------|---|-------|------------------|---|-------|---------------------|---|-------|-------------------|-------------------|------------------------------|---|----------------|----------|
| | | L | I | Score | L | I | Score | L | I | Score | L | I | Score | | | |
| STRATEGIC OBJECTIVE 01: PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES – GOOD BY 2020 | | | | | | | | | | | | | | | | |
| Cautious | Inability to achieve and maintain regulatory compliance | 5 | 5 | 25 | 3 | 4 | 12 | 3 | 4 | 12 | 12 | PROPOSED ACHIEVED | Assurance, Risk & Compliance | Director of Quality Governance | ↑ | |
| Minimal | Non-delivery of the outcomes of the Quality Strategy | 4 | 4 | 16 | 3 | 4 | 12 | 2 | 4 | 8 | 8 | | Quality | Medical Director / Director of Nursing / Director of Quality Governance | ↔ | |
| Avoid | Failure to deliver safe care | 5 | 5 | 25 | 3 | 4 | 12 | 2 | 4 | 8 | 8 | | Quality | Medical Director / Director of Nursing / Director of Quality Governance | ↔ | |
| STRATEGIC OBJECTIVE 02: ENSURE EFFICIENT USE OF RESOURCES | | | | | | | | | | | | | | | | |
| Cautious | Expenditure incurred exceeds income by greater than agreed control total | 4 | 5 | 20 | 5 | 5 | 25 | 3 | 5 | 15 | 15 | | Performance | Director of FEIMT & Deputy CEO | ↔ | |
| STRATEGIC OBJECTIVE 03: PATIENT STANDARDS | | | | | | | | | | | | | | | | |
| Cautious | Failure to deliver patient standards of care including constitutional and contractual levels | 4 | 4 | 16 | 4 | 4 | 16 | 3 | 4 | 12 | 12 | | Performance | Divisional Directors | ↔ | |
| STRATEGIC OBJECTIVE 04: EXCELLENCE IN EMPLOYMENT | | | | | | | | | | | | | | | | |
| Cautious | Attract and recruit the right staff | 4 | 5 | 20 | 3 | 5 | 15 | 3 | 4 | 12 | 12 | | Performance | Director of Human Resources & OD | ↑ | |
| Cautious | Develop and retain the right staff | 4 | 5 | 20 | 4 | 4 | 16 | 3 | 4 | 12 | 12 | | Performance | Director of Human Resources & OD | ↑ | |
| Cautious | Driving cultural change | 5 | 4 | 20 | 3 | 4 | 12 | 3 | 4 | 12 | 12 | PROPOSED ACHIEVED | Performance | Director of Human Resources & OD | ↑ | |
| STRATEGIC OBJECTIVE 05: LEAD STRATEGIC CHANGE ON ISLE OF WIGHT | | | | | | | | | | | | | | | | |
| Open | The future strategy for the provision of health services on Isle of Wight is not sufficiently led by the Trust | 4 | 4 | 16 | 2 | 4 | 8 | 2 | 4 | 8 | 8 | PROPOSED ACHIEVED | Board | Chief Executive | ↑ | |
| Open | Failure to set out and implement an analytics and digital technology strategy/plan | 4 | 4 | 16 | 4 | 4 | 16 | 2 | 4 | 8 | 8 | | Board | Director of FEIMT & Deputy CEO | ↔ | |
| Open | Failure to set out and implement an estates and facilities strategy/plan | 4 | 4 | 16 | 4 | 4 | 16 | 2 | 3 | 6 | 6 | | Board | Director of FEIMT & Deputy CEO | ↔ | |

5.10.5 A further matter considered with each respective lead Executive Director is the risk appetite for each of the strategic objectives and associated risks. A risk appetite view has been included for each of the strategic objectives and associated risks, and these are used as a guide through the organisation as part of risk management processes.

5.10.6 Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value. In other words, the total impact of risk an organisation is prepared to accept in the pursuit of its strategic objectives.

5.10.7 Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

5.10.8 The amount of risk an organisation is willing to accept can vary from one organisation to another depending upon circumstances unique to each. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

5.10.9 The Good Governance Institute (GGI) has produced a briefing paper on risk appetite for NHS organisations with a matrix to support better risk sensitivity in decision-taking and has been used to assess risk appetite for each of the Trust's strategic objectives.

5.10.10 A summary of the risk appetite position statements for each of the strategic sub-level objectives is as follows, as determined by the Board through its meetings in June 2018 and formally approved in July 2018:

| STRATEGIC OBJECTIVES AND STRATEGIC RISKS | RISK APPETITE LEVELS | | | | | |
|--|----------------------|---------|----------|------|------|--------|
| | Avoid | Minimal | Cautious | Open | Seek | Mature |
| PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES – GOOD BY 2020 | | | | | | |
| Inability to achieve and maintain regulatory compliance | | | X | | | |
| Non-delivery of the outcomes of the Quality Strategy | | X | | | | |
| Failure to deliver safe care | X | | | | | |
| ENSURE EFFICIENT USE OF RESOURCES | | | | | | |
| Expenditure incurred exceeds income by greater than agreed control total | | | X | | | |
| PATIENT STANDARDS | | | | | | |
| Failure to deliver patient standards of care including constitutional and contractual levels | | | X | | | |
| EXCELLENCE IN EMPLOYMENT | | | | | | |
| Attract and recruit the right staff | | | X | | | |
| Develop and retain the right staff | | | X | | | |
| Driving cultural change | | | X | | | |
| LEAD STRATEGIC CHANGE ON ISLE OF WIGHT | | | | | | |
| The future strategy for the provision of health services on Isle of Wight is not sufficiently being led by the Trust | | | | X | | |
| Failure to set out and implement an analytics and digital technology strategy/plan | | | | X | | |
| Failure to set out and implement an estates and facilities strategy/plan | | | | X | | |

5.10.11 The risk appetite levels have been considered at regular intervals by the assurance committees and Board throughout the course of the year, and will be refreshed along with the objectives for 2019/20.

| 5.11 | OPERATIONAL RISK SUB-COMMITTEE | 5.12 | WORKFORCE STRATEGIES AND STAFFING |
|--------|--|--------|---|
| 5.11.1 | The Operational Risk Sub-Committee brings together the work with the Board and Committees regarding the Board Assurance Framework and strategic risks and the development of risk management with all operational and corporate functions | 5.12.1 | The NHS faces huge workforce challenges with national shortages in most professions, many trained staff leaving the NHS prematurely, and limitations on international recruitment. As a Trust providing services to an island population we are faced with some unique circumstances which offer both additional challenges and, at the same time, opportunities. |
| 5.11.2 | A series of risk management training was developed and put in place from October 2017 and continues to be rolled-out across all operational services and corporate functions on a recurrent basis including through attendance and support at divisional meetings, with a cycle in place to review risk areas in depth through the sub-committee alongside monthly reviews of all high level risks. | 5.12.2 | To meet these challenges and seize opportunities the Trust recognises that we must be ambitious in our efforts to create a reputation and an environment that encourages the very best people - people with the right skills and values - to join and remain with the Trust. |
| 5.11.3 | Governance principles, as described above, continue to be implemented in each of the Divisions, with a Divisional Board having responsibility for the overall management of the Division, a Quality Committee for Divisional oversight of clinical performance (mortality, audit data, benchmarking), service level patient feedback, team or ward audits, service level risk registers, complaints, incidents and a Performance Committee for Divisional oversight of key performance targets, financial performance and workforce management. Underpinning these meetings are specialty and service meetings to look at clinical performance (mortality, audit data, benchmarking), service level patient feedback, audits, service level risk register, complaints, incidents and lessons learned. Additionally, ward and team meetings are held with the expectation that they will share knowledge and experience; particularly good practice and lessons learned. This model applies consistently across all divisions with adjustments in the content to suit the specific areas of check and challenge within the services they deliver. | 5.12.3 | In July 2018 the Trust approved a Workforce Strategy and Recruitment & Retention Strategy, further strengthened by a Leadership Strategy approved in March 2019 following many months of coproduction with our staff and service users. These three documents describe how we will confront the workforce challenges, embrace the opportunities and work tirelessly to create an environment in which our staff can, confidently, realise their potential and give the very best care possible to our patients and clients. |
| | | 5.12.4 | Alongside the strategic development the Trust has undertaken in 2018/19 work has continued to ensure appropriate assurance is provided to the Board that staffing systems are safe, sustainable and effective – through monthly reports to each of the Quality Committee, Performance Committee, and Board. |
| | | 5.12.5 | Staffing levels take into account evidence-based tools where available, and the Trust has sought external assurance of its acute staffing levels through the year, in addition to the use of professional judgement and outcomes reviews to ensure the levels are appropriate in all services it delivers. |

| | | | |
|---------|---|---------|--|
| 5.12.6 | The Director of Nursing, Midwifery, AHPs and Community Services meets with service lines on a regular basis to review a range of data and information relating to safe staffing including current establishments, vacancies, recruitment and retention programmes, turnover, roster management, sickness/absence levels and compliance with mandatory and statutory training - all of these areas are identified as key within in the National Quality Board (NQB) guidance: <i>'Developing Workforce Safeguards'</i> . | 5.12.11 | Risks in relation to staffing levels are clearly sighted at Board level and the Trust has taken action 2018/19 to adjust service delivery following discussion with commissioners to mitigate the impact on patients safety and experience of staffing level risks. |
| 5.12.7 | Safe staffing reviews are undertaken at least twice daily in the acute setting on a dynamic basis, and reports on a monthly basis comply with the requirements of the National Quality Board guidance. Monthly reports include cross-checks of comparative data on staffing and skill mix with other efficiency and quality metrics. | 5.12.12 | Workforce planning throughout the year has taken account of the guidance as to the factors to be included as detailed below, and support has been provided from NHSI on reviewing our approach. We are clear that the following factors need to be included in our workforce planning; <ul style="list-style-type: none"> • be constructed from robust plans focused at clinical service-line level that draw on available evidence –particularly the Getting It Right First Time (GIRFT) programme – describing 'what good looks like' • ensure multidisciplinary workforce numbers are evidence-based, while considering specific system and organisational requirements • ensure staffing capacity and capability are sustainable and sufficient to provide safe and effective care to patients and service users, taking account of any predictable patterns of variation in demand • take account of financial restraints by setting an accurate and achievable staffing budget agreed by clinicians and the finance department • minimise or negate the need for expensive agency staff by effectively planning the workforce needed for service requirements • inform and be informed by an organisation's clinical strategy, business cases and efficiency plans • encourage leaders, managers and staff to work collectively on the workforce planning process, which should be informed by comprehensive staff engagement |
| 5.12.8 | Monthly reports include cross-checks of comparative data on staffing and skill mix with other efficiency and quality metrics. A six monthly safe staffing report is provided to the Board which reports on progress against NQB guidance and the priorities set out in the previous six month report. | | |
| 5.12.9 | Bi-annual reports including an assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) are provided to the Board for detailed discussion and review, following consideration at assurance committee level on a monthly basis. | | |
| 5.12.10 | As part of the business planning process service lines are required to consider their workforce needs and any changes to establishments, skill mix, or the introduction of new roles. Quality Impact Assessments (QIA) are carried out for all planned changes, service developments, and introduction of new models of care such as the use of nursing apprentices, and involve Executive leadership and approval from the Director of Nursing, Midwifery, AHPs, & Community Services or Medical Director, and Director of Quality Governance. | | |

- include a comprehensive QIA where there is any workforce transformation or redesign including a change in skill mix and/or the introduction of new roles (e.g. physician associates, nursing associates, ACPs)
- set the standard for expected staffing levels – encouraging transparency and enabling staffing decisions to be based on evidence
- be formulated by multidisciplinary teams and consider the whole service and the workforce required to deliver the activity, at the required quality standards; from a financial perspective, this should include realistic calculations of workforce 'headroom' for all professional groups and support workers, and consider likely staffing costs such as a percentage of parental or study leave, to avoid overspending when such leave is required
- promote a proactive rather than reactive approach to staffing because workforce planning is a continuous process and should be continually monitored and reviewed.

5.13 BOARD REGULATORY STATEMENTS

- 5.13.1 The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.
- 5.13.2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.
- 5.13.3 The Board is satisfied that the Trust has established and implements:
- Effective board and committee structures;
 - Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
 - Clear reporting lines and accountabilities throughout its organisation.

- 5.13.4 However, the Board is not yet fully satisfied that the Trust has established and effectively implemented systems and/or processes:
- To ensure compliance with the Trust's duty to operate efficiently, economically and effectively;
 - For timely and effective scrutiny and oversight by the Board of the Trust's operations;
 - To ensure compliance with health care standards binding on the Trust including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
 - For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Trust's ability to continue as a going concern);
 - To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
 - To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
 - To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
 - To ensure compliance with all applicable legal requirements.

- 5.13.5 The Board is satisfied that the systems and/or processes referred to in paragraph 5.13.4 (above) should include but not be restricted to systems and/or processes to ensure:
- That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
 - That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

- The collection of accurate, comprehensive, timely and up to date information on quality of care;
- That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
- That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
- That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

- 5.13.6 The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

- 5.13.7 The Trust has a number of strategic risks associated with being compliant with the above requirements and these correlate with and will be aligned to the Board Assurance Framework for 2019/20.

5.14 CARE QUALITY COMMISSION COMPLIANCE

- 5.14.1 The Trust is not fully compliant with the registration requirements of the Care Quality Commission (CQC). As a consequence, the Trust was placed in to Special Measures by NHS Improvement in April 2017.
- 5.14.2 The Trust remains in Special Measures following a further inspection by CQC during January and February 2018 and has submitted a Provider Information Return in March 2019 in anticipation of a further inspection in the year.

- 5.14.3 The Trust received a warning notice from the CQC in relation to a visit to its Emergency Department in January 2018 which it has worked to address throughout the period to May 2019.

5.15 CONFLICTS OF INTEREST

- 5.15.1 The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

5.16 NHS PENSION SCHEME

- 5.16.1 As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

5.17 EQUALITY, DIVERSITY AND HUMAN RIGHTS

- 5.17.1 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

5.18 CARBON REDUCTION DELIVERY PLANS

- 5.18.1 The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5.19 SUMMARY

5.19.1 As part of its role in ensuring effective direction of the Trust, the Board continuously seeks assurances on the detection and management of significant issues. As Accountable Officer, I ensure that Board members are apprised of real or potential significant issues on a no-surprises basis, both within formal Board meetings and as required between meetings. Electronic briefings or conference call updates are circulated to Non-Executive directors to inform them of any emerging issues in between Board meetings. The Board Assurance Framework is updated to reflect significant issues and the mitigation thereof.

6. REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

6.1 THE TRUST AND THE BOARD

6.1.1 The Trust exists to 'provide goods and services, namely hospital accommodation and services, community health services and ambulance and associated transport services for the purposes of the health service'.

6.1.2 The Trust has a Board of Directors, known as the Trust Board, which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate powers to a Committee of the Board or to one or more executive director(s). This is detailed in the Scheme of Reservation and Delegation.

6.1.3 The Trust Board leads the Trust by undertaking the following key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping and role-modelling a positive culture for the Trust.

6.1.4 The general duty of the Trust Board and each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

6.1.5 Reporting to the Performance Committee of the Board, the Service & Financial Improvement Sub-Committee was established in May 2018, replacing the Financial Recovery Board with the primary duties and responsibilities being to assure the Performance Committee of:

- Oversee delivery at an Executive level of the Trust Service and Financial Improvement plans
- Ensure that appropriate action is taken to minimise the deficit
- Hold to account those responsible for the delivery of financial and CIP targets
- Hold individual Senior Responsible Officers (SROs) to account for the delivery of their outcomes, milestones and overall programme
- Provide oversight and monitoring of the plan to ensure it meets agreed milestones and delivery of the required actions and financial targets
- Ensure Care Groups and Corporate functions have the capacity and capability to realise financial benefits
- Approve all schemes and receive assurance via the Quality Impact Assessment process that there will be no risk of negative impact upon the quality of services
- To provide leadership, advice and guidance to sponsors and project managers including unlocking issues or barriers preventing progress
- Consider and approve, or not, any changes requested by the Accountable Executives for material changes to actions, timescales, resource, etc. within their programme plans.
- Identify, manage and mitigate risks to the plan and maintain an overall risk register

- To ensure service changes align to Trust strategy, objectives and values
- Provide monthly reporting to Performance Board on the status of the plan including highlighting risks and describing mitigation

These are under review following the Trust being placed into Financial Special Measures in order to ensure robust governance arrangements are in place.

6.1.6 The membership of the Service & Financial Improvement Sub-Committee includes:

- Chief Executive (Chair)
- Director of Finance (Co Vice-Chair)
- Medical Director (Co Vice-Chair)
- Director of Acute Services
- Director of Ambulance Services (now Integrated, Urgent & Emergency Care)
- Director of Mental Health and Learning Disability Services
- Director of Nursing, AHPs, Midwifery and & Community Services
- Director of Human Resources and Organisational Development
- Director of Quality Governance

6.1.7 Additionally, the following have been invited to attend:

- Deputy Director of Finance
- Head of PMO
- PMO Finance Lead
- Head of Communications
- Head of Procurement

6.1.8 This Board has met regularly on a monthly basis and has been complemented by a series of Financial Performance Review Meetings with Divisions and Corporate Functions which have been held fortnightly or monthly as required.

6.1.9 The primary duties and responsibilities of the Financial Performance Review Meetings are to assure the Service & Financial Improvement Sub-Committee of:

- Performance against the financial and CIP targets through receipt of:
- Clinical Business Unit finance reports
- RAG reports on all schemes including QIA status

- Status on Project Initiation Documents
- Deficits and gaps in plans
- New ideas
- Plans for "Cross Cutting Schemes"
- Define the RAG status of each scheme
- Recommend that additional projects be added to the programme of work so that risks to the delivery of financial targets are minimised
- Assess the need for extra resource to be provided to projects that are underperforming but which are key to success
- Support cross-division discussion and review of all schemes
- Monitor the PID status for all schemes

6.1.10 The membership has included the following:

- Director of Finance (Chair)
- Director of Human Resources and organisational Development
- Deputy Director of Finance (Vice Chair)
- Division representatives
- Clinical Business Units – Finance Managers x 5
- Senior Representative from Estates
- Senior Representative from Human Resources and Organisational Development
- Senior Representative from IM&T
- Representative of the Project Management Office

6.1.11 The combination of the Service & Financial Improvement Sub-Committee and the Financial Performance Review Meetings has provided significantly improved governance arrangements for ensuring that resources are used economically, efficiently and effectively.

6.1.12 The Service & Financial Improvement Sub-Committee has reported to the Trust's Performance Committee where scrutiny and challenge regarding financial performance and the effective use of resources has enabled the Board to receive overall reports from the Director of Finance, triangulated with reports from the Chair of Performance Committee.

6.1.13 The Trust Board has provided considerable oversight and challenge on the Trust financial position throughout the year, both through formal meetings and through regular calls and briefings in relation to the delivery of financial schemes and the development of the annual operating plan.

7. INFORMATION GOVERNANCE

7.1 SERIOUS INCIDENTS RELATING TO INFORMATION GOVERNANCE

7.1.1 The following are the details of serious incidents during 2018/19 in relation to Information Governance (IG) and recorded as level 6 or above against the breach assessment grid within NHS Digital's Guide to the Notification of Data Security and Protection Incidents. In light of the move to the Data Security and Protection Toolkit a new incident reporting tool for data security and protection incidents has been launched reflecting the revised reporting requirements of the General Data Protection Regulations.

| Reference Ref. | Reported | What happened | Reported to |
|----------------|------------------|---|---|
| 4787 | 01/10/2018 16:04 | Personal and sensitive (special category) data relating to one data subject was disclosed to a 3rd party stakeholder without the data subjects knowledge or consent. | ICO Ref – COM0790796 DATIX - WF69919 latest email response to further questions sent to ICO by Trust on 21.2.19 Status OPEN. |
| 3444 | 04/09/2018 13:46 | Intruders broke into premises used by Mental Health. Information relating to two individuals was found in the street. | ICO Ref – COM0782641 DATIX WF69186 ICO acknowledged incident 6.9.18 – No further communication from ICO as of 17.4.19 Status OPEN. |
| 3439 | 04/09/2018 09:28 | Call made to ambulance control from mental health team requesting ambulance attendance for a patient in respect of whom there was some reason to believe that there was a risk of self-harm. When the ambulance arrived it was established that the patient living at the address is the wrong patient, with the same name as the intended patient. | WF69168 ICO response was that they did not consider this a breach. No further action from ICO Status CLOSED. |

| Reference Ref. | Reported | What happened | Reported to |
|----------------|------------------|---|--|
| 3362 | 28/08/2018 09:31 | The Trust sent a letter to the individual which included her name, address, and a brief outline of a complaint which she had previously made. The letter was wrongly addressed due to an incorrect digit in the house number, and was opened by an unauthorised member of the public. The person contacted the individual by Facebook to say that she had received and opened the letter. | ICO Ref– COM0763396 DATIX - WF68924 Responded 11.7.18 – Linked with 1701. No further ICO action. Status CLOSED. |
| 3353 | 24/08/2018 15:24 | Clerical error which has resulted in lost /erased data for 70 patients | DHSC/NHS England and ICO Ref – COM077882 DATIX -WF68664 ICO latest email response to further questions sent to ICO by Trust 21.2.19 Status OPEN. |
| 2033 | 31/07/2018 11:12 | A Paris system failure has led to the loss of data entry for previous weeks in relation to inpatient ward reviews. It was also noted that documentation for nursing observations on admission were also failing. Staff checked entries for four wards, all of which were showing the same problem. | DHSC/NHS England and ICO Ref - COM0771740 DATIX - WF68259 16.4.19 ICO closure. Status CLOSED. |
| 2016 | 30/07/2018 14:36 | A letter addressed to the data subject was sent to the wrong address, where it was opened and read by an unauthorised member of the public. | ICO – COM0771540 WF68231 Latest email response to ICO 25.3.19 Status OPEN. |
| 1701 | 06/07/2018 15:53 | A recording of a complaint meeting between the CEO and a relative of a deceased patient also contained in error another similar meeting involving another relative's complaint in relation to their deceased relative. | ICO Ref -COM0763396 DATIX - WF67559 16.11.19 response from ICO Status Closed. |
| 281 | 13/06/2018 16:49 | A patient received a copy of their Autism assessment and was going through this with their health visitor at home when the health visitor realised that another report for another patient had also been stapled on the report. | ICO response was that they did not consider this a breach. No further action from ICO Status CLOSED. |

| | | |
|--------------|---|---|
| 7.1.2 | Although all the above cases were referred to the Information Commissioners Office (ICO), no action has yet been taken by the ICO in any of the instances. Several are still open however. Following an audit of the Trust's IG systems and process in 2018 the ICO is returning for a follow up audit in August 2019. | including all Trust staff, CCG, Healthwatch, local police, Local Authority and multiple other agencies. |
| 7.2 | QUALITY ACCOUNT | |
| 7.2.2 | The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. | 7.2.6 In order to ensure that we are compliant with the regulations surrounding the Quality Account, it is audited by Ernst and Young LLP. As part of the audit process, two indicators are selected for review; the Auditors recommended that these continue to be as per the last years audit for continuity. These are: <ul style="list-style-type: none"> • C Diff data collection processes • Care Programme Approach |
| 7.2.3 | At the Quality Committee on 3rd April 2019 draft quality priorities for the next year were discussed and supported. The final Quality Account needs to be approved at Audit Committee in May 2019, with sign off at Trust Board in June to allow us to fulfil our statutory requirement of publishing and uploading to the Secretary of State by 30th June 2019. These priorities were shared with stakeholders to consult on the elements should be incorporated into the annual Quality Accounts. | 7.2.7 Auditors will provide the Trust's management with a signed limited assurance report by 29 June. This will state whether anything has come to their attention that leads them to believe that the Quality Account has not been materially prepared in line with the National Health Service (Quality Accounts) Regulations 2010. |
| 7.2.4 | A Quality Account is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided. | 7.3 PRIORITIES FOR 2018/19 |
| 7.2.5 | Each year, the Trust follows a process to enable completion of the Quality Account. This commences in December by identifying potential Quality Priorities for the forthcoming year and producing a long list of options which are then consulted upon. The consultation goes out on an electronic survey to over 70 key areas | 7.3.2 The Quality Priorities for 2018/19 were <ul style="list-style-type: none"> • Patient Safety: Deteriorating patient; we will recognise deteriorating patients at the earliest opportunity and identify the most appropriate course of treatment for them. • Clinical Effectiveness: Right Patient, Right Place, Right Time; we will ensure that all our patients are located in the most appropriate place from admission to discharge. • Patient Experience: End of Life Care; we will continue to ensure that patients at the end of their lives are treated in line with their wishes and with the utmost dignity and respect, working in partnership with the hospice and others across the Island. |

| | | |
|------------|--|--|
| 7.3.3 | Quality Account priorities have been monitored through committee work-plans and alignment to the Quality Strategy. Significant progress has been seen with regards to the Deteriorating Patient and End of Life priorities, in terms of actions and outcomes. Whilst a great deal of actions have been undertaken for the Right Patient, Right Place, Right Time, these have not yet impacted on outcomes. | that this was necessary to release time to care. Since the event, capital funding has already been obtained for a programme to facilitate cleaning audits and health and safety audits. This system also has the ability for nursing and clinical audits to be added as appropriate. |
| 7.4 | PRIORITIES FOR 2019/20 | |
| 7.4.2 | Monitoring throughout 2019/20 will continue to be through committee work-plans and alignment to the Quality Strategy at both Divisional and Trust-wide level. | 7.4.7 It was determined that insufficient progress, in terms of outcomes as opposed to actions, had been made with regards to Right Patient, Right Place, Right Time. As such, stakeholders felt that this important work-stream should remain a priority in the Quality Accounts for 2019/20. |
| 7.4.3 | The organisational Quality Priorities for the Quality Account are aligned with the Quality Strategy priorities. | 7.4.8 For Experience, stakeholders were pleased with the progress that End of Life Care has made this year. It was acknowledged that this work will continue as part of the Quality Strategy. Stakeholders voted that Dementia be included for 2019/20 as this is another priority that can be applied Island-wide and to all of our care settings. |
| 7.4.4 | An electronic survey has been distributed to all Trust staff and multiple external agencies; as well as postcards sent out to all areas for completion. Staff and external agencies were asked to identify key priorities against Safe, Experience and Effectiveness. | 7.4.9 It is therefore proposed that the following are taken forward for 2019/20 as the Trust's Quality Priorities for the Quality Account: <p><i>Patient Safety:</i></p> <ul style="list-style-type: none"> • Releasing time to care – using information systems appropriately <p><i>Clinical Effectiveness:</i></p> <ul style="list-style-type: none"> • Right Person, Right Place, Right Time; <p><i>Patient Experience:</i></p> <ul style="list-style-type: none"> • Dementia Care |
| 7.4.5 | A stakeholder engagement event was held on 8th March for all parties to review the progress on the 2018/19 priorities and suggest priorities for 2019/20. In the afternoon, a workshop was held to work through the feedback received and select three priorities for 2019/20. Whilst all stakeholders were invited, only the CCG and Trust staff attended. Therefore, the Head of Service Improvement took these proposals along to the Patient Council where they were also supported. | |
| 7.4.6 | Stakeholders told us that the use of information is key to helping us achieve our goals. Examples given included the use of systems, such as Vitalpac, to record patient observations, cleaning audits on an electronic system and continuation of our journey for the electronic patient record. Whilst it was acknowledged that this would need to be refined to what can be achieved in one year, there was strong support | 7.4.10 Whilst the Quality Accounts will focus on these priorities, all of the priorities considered will form part of the three-year Quality Strategy (approved April 2018) with transparent sharing and monitoring of progress throughout each year. |

8 REVIEW OF EFFECTIVENESS

8.1 EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL

8.1.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust that have responsibility for the development and maintenance of the internal control framework.

8.1.2 I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, Assurance, Risk and Compliance Committee, Quality Committee and Performance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

8.1.3 The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.

8.1.4 The overall Head of Internal Audit Opinion for 2018/19 is "Limited" assurance. The Head of Internal Audit reached this conclusion on the basis that weaknesses in the design, and/or inconsistent application of controls, put the achievement of the organisation's objectives at risk in a number of the areas reviewed. Progress was made in a number of key governance areas including notably on the Board Assurance Framework.

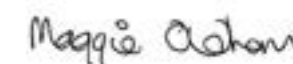
8.1.5 Internal Audit planned to complete 19 reviews across the course of the year, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Trust's objectives.

8.1.6 For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided. Details of those reports where "Limited" assurance has been provided are detailed below. The areas on which assurance assessments have been provided can only provide reasonable and not absolute assurance against misstatement or loss, and their effectiveness is reduced if the internal audit recommendations made during the year have not been fully implemented. Progress on the 19 areas and the level of assurance provided is as set out on the following page:

| Review | Type | Assurance Assessment |
|---|-----------|--|
| Freedom to Speak Up | Assurance | Substantial |
| GDPR Compliance | Assurance | Limited |
| Cyber Security Maturity Assessment | Advisory | N/A |
| Mortality Rates | Assurance | Reasonable |
| Clinical Business Unit – CIP and Expenditure Controls | Assurance | Reasonable |
| E-Rostering | Assurance | <i>TBC – report pending completion</i> |
| Safe Staffing Levels | Assurance | Substantial |
| Major Incident & Business Continuity Planning | Assurance | Limited |
| Financial Accounting & Payroll | Assurance | Reasonable |
| IG Toolkit Part I (DSP) | Advisory | N/A |
| Health & Safety Management | Assurance | Reasonable |
| Network Security | Assurance | Limited |
| Serious Incidents (SI's) | Assurance | Reasonable |
| Procurement | Assurance | Limited |
| Board Assurance Framework & Risk Management | Assurance | Reasonable |
| Risk Maturity | Advisory | N/A |
| Data Quality – KPIs | Assurance | Reasonable |
| Capacity Planning | Assurance | <i>TBC – review underway</i> |
| IG Toolkit Part II | Advisory | N/A |

| | | | |
|--------|--|--------|---|
| 8.1.7 | The internal audits above include a specific data quality audit which supplemented the Trust's internal on-going assessments of data quality of the monitoring and reporting of key performance indicators, such as elective waiting time data through its use of dashboards that contain a series of data quality metrics. | 8.1.11 | In conjunction with this Board, Financial Performance Review Meetings have also been held on a fortnightly or monthly basis dependent on the level of need within particular areas of the Trust, creating the opportunity for detailed challenge to Divisions and Corporate Functions. |
| 8.1.8 | Additional external assurance was also provided through NHSI during 2018/19 who supported the Trust in carrying out a further review of data quality relating to PTL (Patient Tracking List) data. | 8.1.12 | Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives have been reviewed. My review is also informed by: <ul style="list-style-type: none"> Detailed reports from both Internal and External Auditors. Monthly activity, quality, finance and workforce performance reports to the Board. Divisional reports to Trust Leadership Committee. Reports to the Board from Audit Committee. Regular review of the Principal Risk Register, through the Trust Board. CQC confirmation of registration of all regulated activities Information Governance Toolkit self-assessment Internal auditor opinion following internal audit of compliance. |
| 8.1.9 | Board Assurance Committees, as detailed above, provide me with the opportunity for my Executive Directors to report to respective Committees regarding progress and performance against the agreed strategic objectives, regulatory targets and agreed plans and other operational measures. The Non-Executive Directors provide challenge in seeking assurance from the Executive Directors in order for Committee Chairs to report to the Board. In summary: <ul style="list-style-type: none"> Performance Committee – is responsible for overseeing all aspects of financial performance and use of resources, operational performance and workforce performance. Quality Committee – is responsible for overseeing all aspects of quality, including patient safety, patient experience and clinical outcomes. Additionally, it is responsible for overseeing improvement in organisational development. Assurance, Risk and Compliance Committee – has been responsible for overseeing compliance with all regulatory and statutory requirements and the risk management processes. | 8.1.13 | However, despite these controls, the Trust remains in Special Measures for quality and continues to encounter significant financial challenges which resulted in it being placed into Financial Special Measures in March 2019. As Chief Executive and Accountable Officer I have advised the Trust Board, the Audit Committee and the Trust Leadership Committee on the implications of the result of my review of the effectiveness of the system of internal control and collectively we have generated quality, workforce, financial and operational plans which will be monitored and delivered during 2018/19 through the Service & Financial Improvement Sub-Committee. |
| 8.1.10 | Additionally, a Financial Recovery Board was established in January 2018, which evolved in to the Service & Financial Improvement Sub-Committee from May 2018, accountable to the Performance Committee for overseeing the financial recovery plans. This Board has met monthly and has provided an impetus for driving through further cost savings during 2018/19. | | |

| | | | |
|----------|--|-----|---|
| 9 | CONCLUSION | 9.4 | In March 2019 the Trust was placed into Financial Special Measures by NHSI. |
| 9.1 | In summary, there have been a number of significant internal control issues during 2018/19. | 9.5 | Additionally, the Care Quality Commission published a report for the Trust, based on the inspection visits undertaken in January and February 2018. The resulting overall rating from the 2018 visit to the organisation was "Inadequate", with inadequate ratings also attributed to the individual CQC domains of Safe, Responsive and Well-Led. On the basis of the report the Trust has remained in Special Measures for Quality. The Trust has also received a Warning Notice from the CQC following a one-day inspection of the Emergency Department in January 2019, and section 31 restrictions remain in place for aspects of mental health service provision. |
| 9.2 | The Trust had a year-end deficit of £30.1m. This compares to an original Trust plan of £17.1m deficit. The Internal Auditors' opinion on the organisation's system of internal control has taken this factor into account. | | |
| 9.3 | The Head of Internal Audit's opinion is that weaknesses in the design, and/or inconsistent application of controls, put the achievement of the organisation's objectives at risk in a number of the areas reviewed. This opinion is based on <ul style="list-style-type: none"> an assessment of the design and operation of the underpinning Assurance Framework and supporting processes; an assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses. additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances | 9.6 | The Trust did not achieve a number of NHS constitutional targets during 2018/19 and, in part, a contributory factor has been insufficient internal controls, governance, performance management and risk management arrangements in place throughout the year. |
| | | 9.7 | Despite the unacceptable level of internal controls issues during 2018/19 identified above, it is assuring to note the recognised improvements in governance, structures, performance management and risk management that have been made and have started to be embedded during the year. This has provided the basis for further strengthening the internal controls in place during 2019/20. |



Maggie Oldham
Chief Executive Officer

24 May 2019

Details of NEDs

| CHAIR AND NON-EXECUTIVE DIRECTORS | | | | | | | | | | |
|---|---------------------------|---------------------|------------|-----------------------------------|-----------------|---------------|-----------------|--------------------------------------|------------|------------|
| | Vaughan Thomas (Chair) | Kemi Adenubi | Paul Evans | Tim Peachey (Vice Chair & SID) | Caroline Spicer | Anne Stoneham | Phil Berrington | Dr Charles Godden (left 30.04.19) | Sara Weech | |
| Term of Office | | | | | | | | | | |
| Start Date | 07/09/2016 | 28/01/2019 | 01/01/2019 | 01/04/2018 | 01/01/2018 | 01/01/2018 | 01/01/2019 | 01/09/2017 | 01/01/2018 | |
| End of 1st Term | 05/10/2017 | 27/01/2021 | 31/12/2021 | 31/03/2020 | 31/12/2019 | 31/12/2019 | 31/12/2021 | 31/08/2019 | 31/12/2019 | |
| End of 2nd Term | 04/10/2019 | | | | | | | | | |
| End of 3rd Term | | | | | | | | | | |
| Committee Membership and Chairs | Frequency | ToR No. of NEDs | | | | | | | | |
| Quality Committee | Monthly | 3 | | Member | Chair | | | Vice Chair | Member | |
| Performance Committee | Monthly | 3 | | Member | | Chair | Vice Chair | Member | | |
| Nominations & Remuneration Committee | Bi Annual | Chair & Voting NEDs | Chair | Member | Member | Vice Chair | Member | Member | Attendee | Attendee |
| Audit Committee | Quarterly | Voting NEDs | | Attendee | Member | Member | Vice Chair | Member | Chair | Attendee |
| Assurance, Risk & Compliance Committee | Quarterly | 3 | | Vice Chair | | | Member | Chair | Member | |
| Charitable Funds Committee | Quarterly | 3 | | | | | Chair | Member | | Vice Chair |
| Mental Health Act Committee | Quarterly | 4 | | | Vice Chair | Member | | | Chair | Member |
| Lead Non-Executive Directors | | | | | | | | | | |
| Chair | Lead | | | | | | | | | |
| Vice Chair | | | | Lead | | | | | | |
| Senior Independent Director (SID) | | | | Lead | | | | | | |
| Mental Health Act Review Managers (Chairman of Mental Health Act Committee) | | | | Completed | | | | Lead | Completed | |
| End of Life Care | | | | Lead | | | | | | |
| Mortality & Learning from Deaths | | | | Lead | | | | | | |
| Raising Concerns/Whistleblowing | | | | | | Lead | | | | |
| Emergency Planning & Business Continuity | | | | | | | Lead | | | |
| Medical Employment Relations | | | | Lead | | | | | | |
| Equality & Diversity | | | | | | | | | Lead | |

Board as at 1st February 2019



Vaughan Thomas
Chair



Maggie Gilhearn
Chief Executive



Kemi Adenubi
Non-Executive Director



Dr Paul Evans
Non-Executive Director



Dr Tim Peachey
Vice Chair & Senior Independent Director
Non-Executive Director



Caroline Spicer
Non-Executive Director



Suzanne Rostrom
Director of Quality Governance



Mr Alistair Finnerley
Medical Director



Alice Whistler
Director of Nursing, Midwifery, Allied Health Professionals and Community Services



Darren Cathall
Director of Finance, Estates and HR / Deputy Chief Executive



Anne Stoneham
Non-Executive Director



Phil Berrington
Trust Non-Executive Director (Non-Voting)



Dr Charles Godden
Trust Non-Executive Director (Non-Voting)



Sara Weech
Trust Non-Executive Director (Non-Voting)



Dr Nigel Turner
Director of Acute Services (Non Voting)



Anne Fennigson
Director of Human Resources & Organisational Development



Tim Lynch
Director of Integrated Urgent & Emergency Care (non voting)



Dr Lesley Stevens
Director of Mental Health & Learning Disabilities (non voting)

Appendix B - Analysis of Trust Board Members meeting attendance in 2018/19 (Voting and Non-Voting)

| Analysis of Trust Board members' meeting attendance in 2018/19 | | | | | | |
|--|-------------------------|-------------------------------|-------------------------------------|----------------|---|--|
| Committee | Mean NED Attendance (%) | Mean Executive Attendance (%) | Mean Whole Committee Attendance (%) | Meetings (No.) | No. NEDs on committee (at any one time) | No. Execs on Committee (at any one time) |
| Trust Board | 83 | 88 | 86 | 11 | 9 | 9 |
| Audit Committee | 76 | NA | 76 | 5 | 8 | 0 |
| Assurance Risk & Compliance Committee | 100 | 78 | 88 | 4 | 4 | 9 |
| Charitable Funds Committee | 100 | 78 | 89 | 3 | 3 | 3 |
| Performance Committee | 89 | 83 | 85 | 11 | 4 | 6 |
| Mental Health Act Committee | 75 | 42 | 61 | 4 | 4 | 4 |
| Quality Committee | 86 | 72 | 76 | 11 | 3 | 9 |
| Nominations & Remuneration Committee | 83 | NA | 83 | 4 | 9 | 0 |

Staff and remuneration report

Staff report (figures in brackets relate to previous year)

The Isle of Wight NHS Trust employed an average of 3,100 (3,016) staff and at 31 March 2019, the equivalent of 2,717 (2,723) full-time staff were employed. The overall structure of the workforce is summarised in the charts below.

Employees by staff group

During the course of the year the average staff numbers and full time employed were:

| Average Staff Numbers | Full-time employed | Other | TOTAL |
|---|--------------------|-------|-------|
| Medical and dental | 224 | 49 | 273 |
| Ambulance staff | 107 | | 107 |
| Administration and estates | 665 | 23 | 688 |
| Healthcare assistants and other support staff | 622 | 107 | 729 |
| Nursing, midwifery and health visiting staff | 753 | 185 | 938 |
| Scientific, therapeutic and technical staff | 345 | 19 | 364 |
| Other | 1 | | 1 |
| Total average numbers | 2,717 | 383 | 3,100 |
| Number of employees (WTE) engaged on capital projects | 6 | | 6 |

NB: These figures include bank and agency staff.

The organisation employs a number of individuals at Bands 8 and 9 who are shown in the table below as Full Time Employed numbers and as a 'headcount'.

| Band | Full-time employed | Headcount |
|-------|--------------------|-----------|
| 8a | 75.10 | 105 |
| 8b | 29.37 | 33 |
| 8c | 14.38 | 17 |
| 8d | 11.40 | 12 |
| TOTAL | 130.25 | 167 |

NB: These are the numbers as at 31 March 2019.

Employee consultation

The Trust is committed to the principles of partnership working and staff involvement. Partnership working underpins and facilitates the development of sound and effective employee relation. We continue to work closely with our trade union representatives through our Staff Partnership Forum and seek regular feedback from our staff through the annual staff survey and our quarterly pulse surveys.

The Staff Partnership Forum, meets every month (or as required) and includes representatives from professional associations. The objective of the Staff Partnership Forum is to support the efficiency and success of the Trust for the benefit of all through a joint commitment to constructive consultation and negotiation. The forum discusses organisational change and receives updates from the Chief Executive.

The Joint Local Negotiating Committee meets every two months (or as required) and represents the interests of the medical staff. The membership includes the Chief Executive, Medical Director, representatives from medical staff and the British Medical Association (BMA).

Our workforce strategy is designed to address our challenges, build on our successes and to achieve "A Great Place to Work". We will focus on the following:

- Well Led – culture and leadership
- Developing our leaders
- Equality and diversity
- Recruiting and retaining a motivated workforce
- Staff engagement
- Training and development
- Health and wellbeing
- Living within our means

During 2018/19, we launched our leadership development programme. This programme spans our entire workforce providing opportunities for all our staff across all professional groups to engage and develop within our compassionate leadership model. We will monitor our progress by our new Cultural Dashboard and some of the expected outcomes include improvements in our staff survey results, improvements in the health and wellbeing of our staff, improved clinical outcomes and productivity, compassionate leadership behaviours.

Staff sickness and morale

The Trust supports staff through an active occupational health team and a variety of measures to help avoid staff sickness, including stress-related absences. The level of sickness reported at the Trust during the year was:

This year, we have invested in our occupational health (OH) services to provide dedicated support to our staff who have experienced stress, anxiety and depression. Our OH Mental Health Practitioner has been focusing on improving and providing resilience support to help prevent absence and by providing early interventions to staff during episodes of sickness absence.

| Staff Sickness Absence | 2018/19 | 2017/18 | 2016/17 | 2015/16 |
|--|---------|---------|---------|---------|
| Total Days Lost | 50286 | 27256 | 27327 | 25258 |
| Total Staff Years | 4399 | 2669 | 2632 | 2582 |
| Average Working Days Lost | 11 | 10 | 0 | 9.8 |
| Number of Persons Retired on Ill Health Grounds | 0 | 3 | 6 | 2 |
| Total Additional Pension Liabilities Accrued in Year £000s | 0 | 117 | 296 | 28 |

Remuneration report

Section 421 of the Companies Act 2006 requires the preparation of a Remuneration Report containing an annual report on remuneration in accordance with the requirements of Part 3 of Schedule 8 of Statutory Instrument 2008 No 410. Certain information is subject to audit and will be referred to in the audit opinion.

Within the NHS, the remuneration report looks at the senior managers of the NHS body. ‘Senior managers’ are defined as ‘those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole, rather than the decisions of individual directorates or departments.’ For the purposes of this report, this covers the Trust’s Non-Executive and Executive Directors.

Remuneration policy – Executive and Non-Executive Directors

NHS Improvement determines the remuneration of the Chairman and Non-Executive Directors nationally and provides guidance for senior appointments in NHS Trusts, and the Trust has no reason to believe that this position will change in the future.

Exit packages, payment for loss of office or payments or awards to past senior managers During 2018/19, the Trust did not pay any exit packages or compensation for loss of office to senior managers. A small number of senior managers left the Trust during 2017/18, either through secondment or through alternative employment, and the Trust continued to pay the agreed salary for the senior manager until the contract end date.

Exit packages (audited)

The remuneration of any senior manager on ‘Agenda for Change’ terms and conditions of employment would be in line with National Agreements, as negotiated by the Staff Council. Any other Executive Directors’ contract is in accordance with national guidance on executive pay. Where no guidance is given, a discussion would be held at the local Remuneration and Nominations Committee. The membership of this committee is detailed in the Annual Governance Statement. The Trust has no reason to believe that this position will change in the future.

Working in partnership with our physiotherapy teams, through our occupational health service we have been able to provide staff with physiotherapy support. Over 300 employees have been referred to the rapid access physiotherapy service during 2018/19 and the majority felt it helped prevent sickness absence and had a positive effect on both their work and home life.

Our active health and wellbeing group continue to engage with staff on a range of initiatives, and during 2018/19, this included the relocation of our outdoor gym on our St Mary’s Hospital site, promotion of healthy eating, holding health and wellbeing events including health checks, access to exercise classes, cycle-to-work schemes and referrals for weight management.

Other departures

Table 1:

| Exit package cost band (including any special payment element) | Number of compulsory redundancies | Cost of compulsory redundancies | Number of other departures agreed | Cost of other departures agreed |
|---|---|---------------------------------------|--|---------------------------------------|
| | No. | £000 | No. | £000 |
| <£10,000 | 2 | 14 | 4 | 30 |
| £10,000 - £25,000 | 2 | 25 | 8 | 128 |
| £25,001 - £50,000 | 1 | 42 | 6 | 239 |
| £50,001 - £100,000 | | | 1 | 80 |
| £100,001 - £150,000 | | | | |
| £150,001 - £200,000 | 1 | 161 | | |
| >£200,000 | | | | |
| Total | 6 | 242 | 19 | 477 |

Table 2:

| Analysis of other departures | Payments agreed | Total value of agreements £000s |
|---|-----------------|---------------------------------------|
| Voluntary redundancies including early retirement contractual costs | | |
| Mutually agreed resignations (MARS) contractual costs | 19 | 477 |
| Early retirements in the efficiency of the service contractual costs | | |
| Contractual payments in lieu of notice | | |
| Exit payments following employment tribunals or court orders | | |
| Non-contractual payments requiring HMT approval (special severance payments)* | | |
| Total | 19 | 477 |

Salary and pension entitlements of senior managers (audited)

| Remuneration Name and Title | 2018-19 | | | | | | 2017-18 | | | | | |
|---|--|--|---|---|--|--|--|--|---|---|--|--|
| | (a) Salary (inc Other remuneration) (bands of £5,000) | (b) Expense payments (taxable) To nearest £100 £00 | (c) Performance Pay & Bonuses (bands of £5,000) £000 | (d) Long Term Performance Pay & Bonuses (bands of £5,000) £000 | (e) All pension related benefits (bands of £2,500) £000 | (f) Total (a to e) (bands of £5,000) £000 | (a) Salary (inc Other remuneration) (bands of £5,000) £000 | (b) Expense payments (taxable) To nearest £100 £00 | (c) Performance Pay & Bonuses (bands of £5,000) £000 | (d) Long Term Performance Pay & Bonuses (bands of £5,000) £000 | (e) All pension related benefits (bands of £2,500) £000 | (f) Total (a to e) (bands of £5,000) £000 |
| Ms E Richardson - Chair (note 8) | - | - | - | - | - | - | 15-20 | - | - | - | - | 15-20 |
| Dr N Moorman - Non-Executive Director (note 8) | - | - | - | - | - | - | 0-5 | - | - | - | - | 0-5 |
| Mr C Rogers - Non-Executive Director (note 4) | 5-10 | - | - | - | - | 5-10 | 5-10 | - | - | - | - | 5-10 |
| Mrs J Baird - Non-Executive Director (note 8) | - | - | - | - | - | - | 0-5 | - | - | - | - | 0-5 |
| Mr D King - Non-Executive Director (note 4) | 0-5 | - | - | - | - | 0-5 | 5-10 | - | - | - | - | 5-10 |
| Mr V Thomas - Chair (note 3) | 35-40 | - | - | - | - | 35-40 | 20-25 | - | - | - | - | 20-25 |
| Ms C Spicer - Non-Executive Director (note 3) | 5-10 | - | - | - | - | 5-10 | 0-5 | - | - | - | - | 0-5 |
| Ms A Stoneham- Non-Executive Director (note 3) | 5-10 | - | - | - | - | 5-10 | 0-5 | - | - | - | - | 0-5 |
| Mr C Godden- Non-Executive Director (note 1,3) | 5-10 | - | - | - | - | 5-10 | 0-5 | - | - | - | - | 0-5 |
| Ms S Weech- Non-Executive Director (note 1,3) | 5-10 | - | - | - | - | 5-10 | 0-5 | - | - | - | - | 0-5 |
| Ms O Adenubi - Non Executive Director (note 2) | 0-5 | - | - | - | - | 0-5 | | | | | | |
| Mr R Ghosh - Director of Clinical Improvement - Advisor to Board (note 1,4) | 70-75 | - | - | - | 0-2.5 | 75-80 | 15-20 | - | - | - | 2.5-5.0 | 20-25 |
| Mr P Evans - Non Executive Director (note 2) | 0-5 | - | - | - | | 0-5 | | | | | | |
| Mr P Berrington - Non Executive Director (note 1,2) | 0-5 | - | - | - | - | 0-5 | | | | | | |
| Mr T Peachey - Non Executive Director (note 2) | 5-10 | - | - | - | - | 5-10 | | | | | | |
| Ms K Baker - Chief Executive (note 8) | - | - | - | - | - | - | 75-80 | - | - | - | 10-12.5 | 90-95 |
| Mrs C Palmer - Executive Director of Financial & Human Resources (note 8) | - | - | - | - | - | - | 85-90 | - | - | - | 12.5-15 | 100-105 |
| Mr A Sheward - Executive Director of Nursing & Quality (note 9) | 20-25 | - | - | - | 2.5-5 | 25-30 | 95-100 | - | - | - | 12.5-15 | 110-115 |
| Mrs M Oldham - Chief Executive (note 3, 6) | 190-195 | 15,000 | - | - | 0-2.5 | 210-215 | 165-170 | - | - | - | 0-2.5 | 170-175 |
| Mr D Cattell - Director of Finance, Estates & IM&T (note 3,5,6) | 200-205 | - | - | - | 0-2.5 | 205-210 | 160-165 | - | - | - | 0-2.5 | 165-170 |
| Mr S Parker - Medical Director (note 4,5) | 50-55 | - | - | - | 5-7.5 | 60-65 | 85-90 | - | - | - | 7.5-10 | 100-105 |
| Mrs J Pennycook - Director of Human Resources and Organisational Development (note 1,3,5) | 125-130 | 1,585 | - | - | 17.5-20 | 145-150 | 140-145 | - | - | - | 12.5-15 | 155-160 |
| Mr K Bond - Director of Operations - Mental Health Services (note 1,4,5) | 5-10 | - | - | - | 0-2.5 | 10-15 | 80-85 | - | - | - | 10-12.5 | 95-100 |
| Mrs B Stuttle - Director of Nursing (note 1,4,5) | 120-125 | 3,900 | - | - | 0-2.5 | 130-135 | 80-85 | - | - | - | 0-2.5 | 85-90 |
| Mrs S Rostron - Director of Quality Governance (note 3,5) | 110-115 | 10,000 | - | - | 15-17.5 | 140-145 | 15-20 | - | - | - | 2.5-5.0 | 20-25 |
| Mr J Burwell - Executive Director of Strategy & Planning (note 9) | 95-100 | - | - | - | 12.5-15 | 105-115 | 100-105 | - | - | - | 12.5-15 | 115-120 |
| Ms A Webster - Director of Nursing, Midwifery, AHPs & Community Service (note 2) | 20-25 | - | - | - | 2.5-5 | 25-30 | | | | | | |
| Mrs N Turner - Director of Acute Services (note 1,2) | 105-110 | - | - | - | 15-17.5 | 125-130 | | | | | | |
| Ms L Stevens - Director of Mental Health (note 1,2) | 155-160 | - | - | - | 17.5-20 | 175-180 | | | | | | |
| Mr A Flowerdew - Medical Director (note 1,2) | 155-160 | - | - | - | 0-2.5 | 160-165 | | | | | | |
| Mr T Lynch - Director of Integrated Urgent Care (note 1,2) | 35-40 | - | - | - | 0-2.5 | 40-45 | | | | | | |
| Mr P Evans - Medical Leadership - Adviser to Board (note 4) | 5-10 | - | - | - | 0-2.5 | 10-15 | | | | | | |
| Dr M Pugh - Executive Medical Director (note 8) | - | - | - | - | - | - | 140-145 | - | - | - | 17.5-20 | 160-165 |
| Mr M Price - Company Secretary (note 8) | - | - | - | - | - | - | 120-125 | - | - | - | 2.5-5.0 | 125-130 |
| Mrs S Johnston - Acting Executive Director of Nursing & Quality (note 8) | - | - | - | - | - | - | 20-25 | - | - | - | 2.5-5.0 | 25-30 |
| Mr S Stacey - Chief Operating Officer (note) | 15-20 | - | - | - | 0-2.5 | 20-25 | 105-110 | - | - | - | 0-2.5 | 110-115 |
| Band of Highest Paid Director's Total Remuneration (£000) | 210-215 | | | | | | 170-175 | | | | | |
| Median Total Remuneration (£) | 25,934 | | | | | | 26,565 | | | | | |
| Ratio (note 7) | 8.0 | | | | | | 6.3 | | | | | |

NOTES

- (1) All the above senior managers are/were voting members of the Board of Directors except:
- B Stuttle (until 31.01.19)
K Bond (until 31.07.18)
A Flowerdew (from 03.05.18)
T Lynch (from 07.01.19)
L Stevens (from 04.06.18)
N Turner (from 16.04.18)
R Ghosh (until 23.10.18)
J Pennycook (throughout 18/19)
P Berrington (from 01.01.19)
C Godden (throughout 18/19)
S Weech (throughout 18/19)
- (2) The following appointments were made in the year:
- 16.04.18 N Turner as Director of Acute Services
03.05.18 A Flowerdew as Medical Director
01.05.18 T Peachey as Non Executive Director
04.06.18 L Stevens as Director of Mental Health
01.01.19 P Evans as Non Executive Director
01.01.19 P Berrington as Non Executive Director
07.01.19 T Lynch as Director of Integrated Urgent Care
28.01.19 O Adenubi as Non Executive Director
04.02.19 A Webster as Director of Nursing, Midwifery, AHPs & Community Service
- (3) The remaining Directors not shown in note 2 - continued to serve on the Board throughout the year and remain as Directors as at the date of this Annual Report and Accounts.
- (4) The following persons were Directors at 1st April 2018 but ceased to serve on the Board during the year:
- 07.06.18 D King resigned as Non Executive Director
30.06.18 S Parker ceased as Medical Director
31.07.18 K Bond resigned as Director of Operation - Mental Health Services
23.10.18 R Ghosh resigned as Board Adviser
31.12.18 P Evans ceased as Medical Leadership Adviser to Board
28.01.19 C Rogers resigned as Non Executive Director
31.01.19 B Stuttle resigned as Director of Nursing and Quality
- (5) The above named executive directors have service contracts with the Trust.
- (6) The Chief Executive Officer and Director of Finance, Estates & IM&T are contractually entitled to performance bonuses as part of their remuneration but both declined to be paid this element.
- (7) Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in the Isle of Wight NHS Trust in the financial year 2018/19 was £210,000 - £215,000 (2017/18 - £170,000 - £175,000). This was 8.0 times (2017/18 - 6.3 times) the median remuneration of the workforce, which was £25,934 (2017/18 - £26,565). In 2018/19, 3 employees received remuneration which was proportionately higher than that received by the highest paid director (2017/18 - 3 employees). Total remuneration includes salary, on-call payments, non-consolidated performance related pay, benefits in kind as well as severance payments and is calculated on a Full Time Equivalent basis. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Remuneration ranged from £12k to £301k.
- (8) These are only included to show comparative figures for 2017/18.
- (9) These senior managers paid until the contract end date - Sheward 23.06.18, Burwell 28.02.19.
- (10) Mr A Thorne acted as Quality Improvement Director throughout the year on secondment from NHSI at no cost to the Trust

Employee benefits 2018/19

| Employee benefits | 2018/19 Total £000s | 2017-18 Total £000s |
|--|---------------------------|---------------------------|
| Employee Benefits - Gross Expenditure | | |
| Salaries and wages | 106,115 | 99,106 |
| Social security costs | 10,641 | 9,971 |
| Apprenticeship levy | 500 | 483 |
| Employer's contributions to NHS pensions | 12,223 | 11,725 |
| Pension cost - other | 21 | 10 |
| Other post employment benefits | 0 | 0 |
| Other employment benefits | 0 | 0 |
| Termination benefits | 242 | 122 |
| Temporary staff | 11,678 | 10,891 |
| Total Employee Benefits | 141,420 | 132,308 |
| Employee Costs Capitalised | 403 | 438 |
| Gross Employee Benefits | 141,017 | 131,870 |

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, the value of any benefits transferred from another pension scheme or arrangement and uses common market valuation factors for the start and end of the period. A CETV is not provided once a scheme member reaches age 60.

| Pension Benefits Name and title | (a) Real increase in pension at age 60 | (b) Real increase in pension lump sum at age 60 | (c) Total accrued pension at age 60 at 31 March 2019 | (d) Lump sum at age 60 related to accrued pension at 31 March 2019 | (e) Cash Equivalent Transfer Value at 1 April 2018 | (f) Real Increase in Cash Equivalent Transfer Value | (g) Cash Equivalent Transfer Value at 31 March 2019 | (h) Employers Contribution to Stakeholder Pension |
|--|--|--|---|---|---|---|--|---|
| | (bands of £2500) £000 | (bands of £2500) £000 | (bands of £5000) £000 | (bands of £5000) £000 | £000 | £000 | £000 | £000 |
| Mrs N Turner - Director of Acute Services | 2.5 - 5.0 | 0 | 30.0 - 35.0 | 70.0 - 75.0 | 469 | 53 | 538 | 0 |
| Mr S Parker - Medical Director | 5.0 - 7.5 | 15.0 - 17.5 | 20.0 - 25.0 | 60.0 - 65.0 | 0 | 129 | 518 | 0 |
| Mrs J Pennycook - Director of Human Resources and Organisational Development | 0.0 - 2.5 | 2.5 - 5.0 | 20.0 - 25.0 | 70.0 - 75.0 | 438 | 98 | 548 | 0 |
| Mr K Bond - Director of Operations - Mental Health Services | 0 | 0 | 25.0 - 30.0 | 80.0 - 85.0 | 605 | 16 | 672 | 0 |
| Mrs S Rostron - Director of Quality Governance | 20.0 - 22.5 | 52.5 - 55.0 | 20.0 - 25.0 | 50.0 - 55.0 | 0 | 350 | 350 | 0 |
| Ms L Stevens - Director of Mental Health | 45.0 - 47.5 | 132.5 - 135 | 55.0 - 60.0 | 160.0 - 165.0 | 0 | 1,031 | 1,250 | 0 |
| OPTED OUT OF PENSION SCHEME | | | | | | | | |
| Mrs M Oldham - Chief Executive | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 0 | 0 | 0 | 0 |
| Mr D Cattell - Director of Finance, Estates & IM&T | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 0 | 0 | 0 | 0 |
| Mrs B Stuttle - Director of Nursing | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 0 | 0 | 0 | 0 |
| Mr S Stacey - Chief Operating Officer | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 0 | 0 | 0 | 0 |
| Mr T Lynch - Director of Integrated Urgent Care | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 0 | 0 | 0 | 0 |
| Mr R Ghosh - Director of Clinical Improvement - Advisor to Board | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 0 | 0 | 0 | 0 |
| Mr P Evans - Medical Leadership - Adviser to Board | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 0 | 0 | 0 | 0 |
| Ms A Webster - Director of Nursing, Midwifery, AHPs & Community Service | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 0 | 0 | 0 | 0 |
| Mr A Flowerdew - Medical Director | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 0 | 0 | 0 | 0 |
| NO LONGER WITH THE TRUST | | | | | | | | |
| Mr A Sheward - Executive Director of Nursing & Quality | 0.0 - 2.5 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 429 | 0 | 0 | 0 |
| Mr J Burwell - Executive Director of Strategy & Planning | 0 | 0.0 - 2.5 | 0.0 - 5.0 | 0.0 - 5.0 | 38 | 0 | 0 | 0 |

NB: There are no entries for Non-Executive Directors in the table because their remuneration is non-pensionable.

Fair pay disclosure

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires that from 31 March 2017, any public sector organisation that has 250 or more employees must publish and report specific figures about their gender pay gap. The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings. For example, 'women earn 15% less than men per hour'. Employers must both publish their gender pay gap data and a written statement on their website and report their data to government online - using the gender pay gap reporting service. The overall pay difference at the Isle of Wight NHS Trust is 19% higher for men than women. More information can be found in our Gender Pay Gap Report published at www.iow.nhs.uk/Publications/gender-pay-gap-report.htm.

Appraisal and performance

The review of the performance of any senior manager on agenda for change terms and conditions of employment would be in accordance with the Trust's appraisal policy. The Trust Board are also appraised. The Chairman undertakes the appraisal of the Chief Executive and Non-Executive Directors. The Executive Directors are appraised by the Chief Executive. Any pay award to other directors would take account of national guidance and appraisal outcomes.

During 2018/19, agenda for change terms and conditions of employment allowed for pay progression to be held at the first, and second, gateways should performance not be satisfactory. From 1 April 2019, there are changes these national terms and conditions in respect of pay progression. During 2019/20, we will be implementing these changes in accordance with the national agreement.

Duration of contracts, notice periods and termination payments

Substantive appointments are made on a permanent basis, and temporary arrangements would be on the appropriate period of a fixed-term contract. Any senior manager on Agenda for Change terms and conditions of employment (Pay Band 8 and above) are on three months' period of notice. Other director contracts (VSM) are required to give six months' period of notice.

Off-payroll engagements

As part of the Review of Tax Arrangements of Public Sector Employees, published by the Chief Secretary to the Treasury on the 23 May 2012, NHS bodies are required to publish information in their Annual Report regarding off-payroll engagements where payment was more than £245 per day and lasted six months or longer. Between the 1 April 2018 and the 31 March 2019, the Trust had no 'off-payroll' engagements of this nature.

Consultancy services

The financial accounts show that the Trust spent £2.880m on consultancy services during 2018/19 compared to £1.648m in 2017/18 and £611k in 2016/17.

Equality disclosures

The Trust has a comprehensive range of policies and procedures promoting equality and the elimination of harassment, bullying and discrimination.

The Trust's Equality and Diversity Strategy was published in June 2018. It sets out how it will increase the visibility of equality and diversity over the next four years. The strategy can be found at <https://www.iow.nhs.uk/about-us/Equality-and-diversity/equality-and-diversity.htm> Other reports relating to Equality and Diversity, Gender Pay Gap and Workplace Race Equality Standard Reports can also be found here. 96% per cent of staff have received some form of equality and diversity training.

Staff who raise concerns of bullying, harassment or discrimination can also be supported by our anti-bullying advisors and/or our freedom to speak up advocates as well as human resources, trade union representatives and occupational health. Staff can also see help and support from our dedicated staff Mental Health and Wellbeing Practitioner.

Staff policies in respect of disabled persons

The Trust has a range of policies that provide for the full and fair consideration to employment applications made by people with a disability, having regard to their particular aptitudes and abilities. Our Equality, Diversity and Human Rights Policy sets out our commitment to a positive and inclusive work environment, where we place a high value on diversity and fairness. The Trust is committed to creating a culture in which equality, diversity and human rights are promoted actively and unlawful discrimination is not tolerated. The Trust recognises that the experiences and needs of every individual are unique and strives to respect and value the diversity of its patients, service users, carers, public and staff.

Where issues arise during employment, policies provide for continuing the employment of, and for arranging appropriate training for, employees who have become disabled during their employment.

The Trust policies do not permit discrimination against disabled people in respect of training, career development and/or promotion. Our policies can be found at www.iow.nhs.uk/about-us/policies_and_strategies.htm

Education, training and organisational development

We have had a successful Education Quality Review meeting with Health Education England. All of the Trust's quality standards - through our Learning and Development Agreement - were met. The Education, Training and Organisational Development team are at the forefront of ensuring our staff are appropriately skilled and up-to-date with the latest developments for the benefit of our patients and service users.

Getting to Good

Training and awareness programme boosts levels of Oxygen prescription

Oxygen prescribing standards have significantly improved after changes were made to staff training and steps taken to raise awareness levels across the Trust.

Average prescription levels have risen to as high as 78 per cent in some weeks, up dramatically from previous levels that saw some wards below 10 per cent in 2017.

The turnaround follows the establishment of a multidisciplinary working group led by Sarah Kearney, a specialist respiratory nurse, and comprising nursing, physiotherapy and pharmacy staff, overseen by a respiratory consultant. The working group aimed to overhaul the way oxygen is prescribed and recorded within the Trust.

It is recommended that all patients have oxygen prescribed for them whilst in hospital in case it is needed, and that oxygen should be recognised as a medicine.

Trade Union (Facility Time Publication Requirements) Regulations 2017

Information on the amount and cost of facility time given to Trade Union representatives as specified within the Trade Union (facility Time Publication Requirements) Regulations 2017 is shown below:

Table 1: Relevant Union Officials

| Number of employees who were relevant union officials 2018/19 | Full time equivalent employee number |
|---|--------------------------------------|
| 16 | 15.53 |

Table 2: Percentage of time spent on facility time

The number of employees who were relevant union officials employed during 2018/19 year spent a) 0%, b) 1%-50%, c) 51%-99%, or d) 100% of their working time on facility time.

| Percentage of time during 2018/19 year | Number of employees |
|--|---------------------|
| 0% | 8 |
| 1% - 50% | 7 |
| 51% - 99% | 1 |
| 100% | 0 |

Table 3: Percentage of pay bill spent on facility time

| Pay bill | Value |
|---|--------------|
| The total cost of facility time | £33,480.64 |
| Total pay bill | £141,016,550 |
| The percentage of the total pay bill spent on facility time | 0.024% |

Table 4: Paid trade union activities

| Time spent on trade union activities as a percentage of total paid facility time |
|--|
| 16.99% |

Highlights from 2018/19 include...

Clinical Education, Mandatory and General Training

- We successfully recruited a cohort of Registered Nurse Degree apprentices and Trainee Nurse Associates. Our processes and placement schedules have been commended by Health Education England and recognised in the House of Lords sub-committee through our innovative work with the Open University. A second cohort will be recruited during 2019.
- Successful outcomes were achieved following an improvement plan for mandatory training resulting in 9,000 hours being removed from competency profiles, releasing staff to care. This contributed towards the organisation exceeding its compliance target of 85% for statutory training for the first time.
- Significant improvements were made to our corporate induction with a new 'values based' introduction day followed by a two-week clinical induction to ensure our new clinical staff are appropriately trained and safe to practice from the start of their employment with us.
- An average of 70 staff were undertaking apprenticeship programmes at any time during 2018, studying all levels through to Foundation and Post Graduate Degree programmes.

- 29 staff completed the Preceptorship programme during the year, with 67 completing the Care Certificate programme.
- The equivalent of 70 (WTE) non-medical learners were supported during 2019.

Leadership & OD

- Over 77% of staff had an annual appraisal during the year.
- 382 staff attended corporate inductions during 2018/19. The new format 'values based' induction day, introduced in November, has been very positively evaluated.
- Considerable work has been undertaken through the Culture and Leadership programme, including:
 - Engagement with more than 700 staff and patients through surveys, focus groups and one-to-one interviews to seek feedback on the organisation's culture and leadership.
 - Approval by Trust Board of our new Leadership Strategy with associated action plan for 2019-21.
 - Refresh of our organisation's vision, values and behaviours.
 - Implementation of an extensive leadership development framework incorporating programmes for the executives, senior and middle leadership teams. Programmes for team leaders/supervisors and others to commence later in 2019.
 - Publication of Culture Dashboards for the whole organisation as well as each clinical division to provide an indication of culture through key measures aligned to our values.
 - Implementation of a monthly staff survey to regularly check key indicators related to staff engagement, wellbeing, communication and whether they would recommend the organisation as a place to work and have care or treatment.
 - A leadership conference was held with nearly 300 attendees and inspirational guest speakers Professor Michael West, Michael McGrath, Peter Lees (MD for Faculty of Medical Leadership and Management) and Katy Steward. Around 100 attendees were from other NHS organisations (regional and national), voluntary and private sector organisations.

- Our annual staff survey results were very challenging and we have been working with service and department leads to put improvement plans in place.

Medical education

Work has been completed on the high-fidelity academic skills suite which will be officially opened in the spring. This new skills suite will be named the Allison Harries Academic Skills Suite in memory of Allison Harries.

An additional 17 senior medical staff have completed training as accredited Health Education England (Wessex) educational and named clinical supervisor course to supervise doctors in training. This increases the number of educators available to support doctors in training.

The faculty of Medical Leadership is currently delivering a number of leadership sessions for senior consultant medical staff.

A number of Human Factors Hospital at Night training sessions have been delivered to support the new model of Hospital at Night working. The Hospital at Night and handover process have been updated and improved.

Library and Knowledge Services (LKS)

- Achieved 94% in the annual Library Quality Assurance Framework accreditation.
- Two case studies of direct impact of LKS on patient care accepted into the national database.
- Now offering DynamedPlus and BMJ Best Practice immediate point-of-care evidence resources.
- 17,871 episodes of electronic or staff-mediated information provision or training in the year.
- New e-learning modules required are now more interactive using Storyline software.
- 289 staff are now registered for IT skills pathway modules.

Maggie Oldham

Maggie Oldham
Chief Executive Officer / Accountable Officer
Isle of Wight NHS Trust
24 May 2019

Annual accounts for the year ended 31 March 2019

Statement of Comprehensive Income

| | Note | 2018/19 £000 | 2017/18 £000 |
|---|------|-----------------|-----------------|
| Operating income from patient care activities | 3 | 160,771 | 155,529 |
| Other operating income | 4 | 14,909 | 15,866 |
| Operating expenses | 7, 9 | (202,947) | (190,608) |
| Operating surplus/(deficit) from continuing operations | | (27,182) | (19,213) |
| Finance income | 12 | 38 | 16 |
| Finance expenses | 13 | (1,186) | (679) |
| PDC dividends payable | | (1,837) | (2,873) |
| Net finance costs | | (2,985) | (3,536) |
| Other gains / (losses) | 14 | (36) | (5) |
| Share of profit / (losses) of associates / joint arrangements | | - | - |
| Gains / (losses) arising from transfers by absorption | | - | - |
| Corporation tax expense | | - | - |
| Surplus / (deficit) for the year from continuing operations | | (30,288) | (22,754) |
| Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations | 15 | - | - |
| Surplus / (deficit) for the year | | (30,288) | (22,754) |

Other comprehensive income

Will not be reclassified to income and expenditure:

| | Note | 2018/19 £000 | 2017/18 £000 |
|--|------|-----------------|-----------------|
| Impairments | 8 | (17,418) | - |
| Revaluations | 19 | 3,809 | 6,080 |
| Share of comprehensive income from associates and joint ventures | | - | - |
| Fair value gains/(losses) on equity instruments designated at fair value through OCI | | - | - |
| Other recognised gains and losses | | - | - |
| Remeasurements of the net defined benefit pension scheme liability / asset | | - | - |
| Other reserve movements | | - | - |

May be reclassified to income and expenditure when certain conditions are met:

| | | |
|---|---|---|
| Fair value gains/(losses) on financial assets mandated at fair value through OCI | - | - |
| Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI | - | - |
| Foreign exchange gains / (losses) recognised directly in OCI | - | - |

| | | |
|--|-----------------|-----------------|
| Total comprehensive income / (expense) for the period | (43,897) | (16,674) |
|--|-----------------|-----------------|

Adjusted financial performance (control total basis):

| | | |
|---|----------|----------|
| Surplus / (deficit) for the period | (30,288) | (22,754) |
| Remove impact of consolidating NHS charitable fund | - | - |
| Add back all I&E impairments / (reversals) | 105 | - |
| Remove (gains) / losses on transfers by absorption | - | - |
| Remove I&E impact of capital grants and donations | 81 | 87 |
| Prior period adjustments | - | - |
| Remove non-cash element of on-SoFP pension costs | - | - |
| CQUIN risk reserve adjustment (2017/18 only) | - | (583) |
| Remove 2016/17 post audit STF reallocation (2017/18 only) | - | - |

| | | |
|---|-----------------|-----------------|
| Adjusted financial performance surplus / (deficit) | (30,102) | (23,250) |
|---|-----------------|-----------------|

Statement of Financial Position

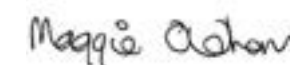
| | Note | 31 March 2019 £000 | 31 March 2018 £000 |
|--|------|-----------------------|-----------------------|
| Non-current assets | | | |
| Intangible assets | 16 | 2,956 | 2,643 |
| Property, plant and equipment | 17 | 108,542 | 122,438 |
| Investment property | | - | - |
| Investments in associates and joint ventures | | - | - |
| Other investments / financial assets | | - | - |
| Receivables | 21 | 251 | 286 |
| Other assets | | - | - |
| Total non-current assets | | 111,749 | 125,367 |
| Current assets | | | |
| Inventories | 20 | 2,278 | 2,279 |
| Receivables | 21 | 10,552 | 10,610 |
| Other investments / financial assets | | - | - |
| Other assets | | - | - |
| Non-current assets held for sale / assets in disposal groups | | - | - |
| Cash and cash equivalents | | 4,487 | 5,999 |
| Total current assets | | 17,317 | 18,888 |
| Current liabilities | | | |
| Trade and other payables | 23 | (19,133) | (20,339) |
| Borrowings | 26 | (351) | (109) |
| Other financial liabilities | | - | - |
| Provisions | 28 | (187) | (312) |
| Other liabilities | 25 | (1,944) | (2,278) |
| Liabilities in disposal groups | | - | - |
| Total current liabilities | | (21,615) | (23,038) |
| Total assets less current liabilities | | 107,451 | 121,217 |

| | Note | 31 March 2019 £000 | 31 March 2018 £000 |
|--------------------------------------|------|-----------------------|-----------------------|
| Non-current liabilities | | | |
| Trade and other payables | 23 | (21) | (22) |
| Borrowings | 26 | (68,240) | (38,252) |
| Other financial liabilities | | - | - |
| Provisions | 28 | (170) | (165) |
| Other liabilities | 25 | - | - |
| Total non-current liabilities | | (68,431) | (38,439) |
| Total assets employed | | 39,020 | 82,778 |
| Financed by | | | |
| Public dividend capital | | 7,861 | 7,722 |
| Revaluation reserve | | 33,592 | 47,290 |
| Financial assets reserve | | - | - |
| Other reserves | | - | - |
| Merger reserve | | - | - |
| Income and expenditure reserve | | (2,433) | 27,766 |
| Total taxpayers' equity | | 39,020 | 82,778 |

The notes on the following pages form part of these accounts.

Name **Maggie Oldham**
Position **Chief Executive**
Date **24 May 2019**

Signed



Statement of Changes in Equity for the year ended 31 March 2019

| | Public dividend capital £000 | Revaluation reserve £000 | Financial assets reserve £000 | Other reserves £000 | Merger reserve £000 | Income and expenditure reserve £000 | Total £000 |
|---|---------------------------------------|--------------------------------|--|---------------------------|---------------------------|--|-----------------|
| Taxpayers' equity at 1 April 2018 - brought forward | 7,722 | 47,290 | - | - | - | 27,766 | 82,778 |
| Impact of implementing IFRS 15 on 1 April 2018 | - | - | - | - | - | - | - |
| Impact of implementing IFRS 9 on 1 April 2018 | - | - | - | - | - | - | - |
| Surplus/(deficit) for the year | - | - | - | - | - | (30,288) | (30,288) |
| Transfers by absorption: transfers between reserves | - | - | - | - | - | - | - |
| Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits | - | - | - | - | - | - | - |
| Other transfers between reserves | - | (89) | - | - | - | 89 | - |
| Impairments | - | (17,418) | - | - | - | - | (17,418) |
| Revaluations | - | 3,809 | - | - | - | - | 3,809 |
| Transfer to retained earnings on disposal of assets | - | - | - | - | - | - | - |
| Share of comprehensive income from associates and joint ventures | - | - | - | - | - | - | - |
| Fair value gains/(losses) on financial assets mandated at fair value through OCI | - | - | - | - | - | - | - |
| Fair value gains/(losses) on equity instruments designated at fair value through OCI | - | - | - | - | - | - | - |
| Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI | - | - | - | - | - | - | - |
| Foreign exchange gains/(losses) recognised directly in OCI | - | - | - | - | - | - | - |
| Other recognised gains and losses | - | - | - | - | - | - | - |
| Remeasurements of the defined net benefit pension scheme liability/asset | - | - | - | - | - | - | - |
| Public dividend capital received | 139 | - | - | - | - | - | 139 |
| Public dividend capital repaid | - | - | - | - | - | - | - |
| Public dividend capital written off | - | - | - | - | - | - | - |
| Other movements in public dividend capital in year | - | - | - | - | - | - | - |
| Other reserve movements | - | - | - | - | - | - | - |
| Taxpayers' equity at 31 March 2019 | 7,861 | 33,592 | - | - | - | (2,433) | 39,020 |

Statement of Changes in Equity for the year ended 31 March 2018

| | Public dividend capital £000 | Revaluation reserve £000 | Available for sale investment reserve £000 | Other reserves £000 | Merger reserve £000 | Income and expenditure reserve £000 | Total £000 |
|---|---------------------------------------|--------------------------------|--|---------------------------|---------------------------|--|---------------|
| Taxpayers' equity at 1 April 2017 - brought forward | 6,762 | 41,242 | - | - | - | 50,488 | 98,492 |
| Prior period adjustment | - | - | - | - | - | - | - |
| Taxpayers' equity at 1 April 2017 - restated | 6,762 | 41,242 | - | - | - | 50,488 | 98,492 |
| Surplus/(deficit) for the year | - | - | - | - | - | (22,754) | (22,754) |
| Transfers by absorption: transfers between reserves | - | - | - | - | - | - | - |
| Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits | - | - | - | - | - | - | - |
| Other transfers between reserves | - | (32) | - | - | - | 32 | - |
| Impairments | - | - | - | - | - | - | - |
| Revaluations | - | 6,080 | - | - | - | - | 6,080 |
| Transfer to retained earnings on disposal of assets | - | - | - | - | - | - | - |
| Share of comprehensive income from associates and joint ventures | - | - | - | - | - | - | - |
| Fair value gains/(losses) on available-for-sale financial investments | - | - | - | - | - | - | - |
| Recycling gains/(losses) on available-for-sale financial investments | - | - | - | - | - | - | - |
| Foreign exchange gains/(losses) recognised directly in OCI | - | - | - | - | - | - | - |
| Other recognised gains and losses | - | - | - | - | - | - | - |
| Remeasurements of the defined net benefit pension scheme liability/asset | - | - | - | - | - | - | - |
| Public dividend capital received | 960 | - | - | - | - | - | 960 |
| Public dividend capital repaid | - | - | - | - | - | - | - |
| Public dividend capital written off | - | - | - | - | - | - | - |
| Other movements in public dividend capital in year | - | - | - | - | - | - | - |
| Other reserve movements | - | - | - | - | - | - | - |
| Taxpayers' equity at 31 March 2018 | 7,722 | 47,290 | - | - | - | 27,766 | 82,778 |

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve / Available-for-sale investment reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevivable election at recognition.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

| | Note | 2018/19 £000 | 2017/18 £000 |
|---|------|-----------------|-----------------|
| Cash flows from operating activities | | | |
| Operating surplus / (deficit) | | (27,182) | (19,213) |
| Non-cash income and expense: | | | |
| Depreciation and amortisation | 7 | 6,731 | 6,484 |
| Net impairments | 8 | 105 | 3 |
| Income recognised in respect of capital donations | 4 | (48) | (46) |
| Amortisation of PFI deferred credit | | - | - |
| Non-cash movements in on-SoFP pension liability | | - | - |
| (Increase) / decrease in receivables and other assets | | 420 | (3,838) |
| (Increase) / decrease in inventories | | 1 | (6) |
| Increase / (decrease) in payables and other liabilities | | 118 | 2,005 |
| Increase / (decrease) in provisions | | (120) | (138) |
| Tax (paid) / received | | - | - |
| Operating cash flows from discontinued operations | | - | - |
| Other movements in operating cash flows | | - | - |
| Net cash generated from / (used in) operating activities | | (20,060) | (14,749) |
| Cash flows from investing activities | | | |
| Interest received | | 38 | 16 |
| Purchase and sale of financial assets / investments | | - | - |
| Purchase of intangible assets | | (1,318) | (1,381) |
| Sales of intangible assets | | - | - |
| Purchase of property, plant, equipment and investment property | | (7,134) | (6,300) |
| Sales of property, plant, equipment and investment property | | 23 | 2 |
| Receipt of cash donations to purchase capital assets | | - | - |
| Prepayment of PFI capital contributions | | - | - |
| Investing cash flows of discontinued operations | | - | - |
| Cash movement from acquisitions / disposals of subsidiaries | | - | - |
| Net cash generated from / (used in) investing activities | | (8,391) | (7,663) |

Notes to the Accounts

| | Note | 2018/19 £000 | 2017/18 £000 |
|---|-----------|-----------------|-----------------|
| Cash flows from financing activities | | | |
| Public dividend capital received | | 139 | 960 |
| Public dividend capital repaid | | - | - |
| Movement on loans from the Department of Health and Social Care | | 30,102 | 23,800 |
| Movement on other loans | | - | - |
| Other capital receipts | | - | - |
| Capital element of finance lease rental payments | | (109) | (106) |
| Capital element of PFI, LIFT and other service concession payments | | - | - |
| Interest on loans | | (995) | (585) |
| Other interest | | (2) | - |
| Interest paid on finance lease liabilities | | (15) | (18) |
| Interest paid on PFI, LIFT and other service concession obligations | | - | - |
| PDC dividend (paid) / refunded | | (2,173) | (2,930) |
| Financing cash flows of discontinued operations | | - | - |
| Cash flows from (used in) other financing activities | | (8) | (5) |
| Net cash generated from / (used in) financing activities | | 26,939 | 21,116 |
| Increase / (decrease) in cash and cash equivalents | | (1,512) | (1,296) |
| Cash and cash equivalents at 1 April - brought forward | | 5,999 | 7,295 |
| Prior period adjustments | | - | - |
| Cash and cash equivalents at 1 April - restated | | 5,999 | 7,295 |
| Cash and cash equivalents transferred under absorption accounting | | - | - |
| Unrealised gains / (losses) on foreign exchange | | - | - |
| Cash and cash equivalents at 31 March | 22 | 4,487 | 5,999 |

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis, as there is no indication that the healthcare and other services will not continue to be provided by the public sector for the foreseeable future and that continuing financial support will be provided by DHSC.

This year the Trust has struggled to meet its financial targets against a backdrop of increased financial pressure across the NHS, and entered Financial Special Measures in March 2019. A Finance Improvement Director was appointed by NHS Improvement in March 2019 to provide additional

support in recovering the financial position.

For 2018/19 the Trust has returned a deficit of £30.1m and has achieved £6.8m savings through the Cost Improvement Programme. The DHSC provided deficit funding of £30.1m as revenue support loans in year bringing the total revenue support loan funding to £67.9m at 31 March 2019. Regulatory oversight undertakings have been in operation during the year and the Trust is focused on exiting from Quality Special Measures by 2020.

The Trust's control total for 2019/20 is a deficit of £3.999m, which includes £17.502m of PSF and FRF funding, and is expected to be achieved by the Trust. The plans reflect assumed continued revenue deficit support funding from DHSC for the £3.999m deficit, and this support funding is authorised by DHSC monthly in advance. Deficit support funding of £2.7m for April and £0.7m for May has been provided to the Trust and £0.556m for June has been requested from DHSC.

The Trust has a contract agreement with the Isle of Wight CCG for 2019-20 for a value of £143.7m. The Trust also has in place a contract with NHS England for £8.6m.

The Trust's 2019/20 cash flow forecast is based on the assumptions in the 2019/20 financial plan. The key assumptions underpinning the cash flow are receipt of £3.999m revenue support loan from the DHSC to finance the revenue deficit, and £17.502m of PSF and FRF funding.

The cash flow position is reported to the Performance Committee and the Board monthly and this is based on the Trust's detailed cash flow forecast which is updated daily.

Taking into account all these factors, the assumption that the healthcare and other services will continue to be provided by the public sector for the foreseeable future and that the DHSC will continue to provide financial support, the Board consider the Trust will continue to operate as a going concern. The conditions described above do, however, indicate the existence of material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern.

The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Note 1.2 Critical Judgements in applying Accounting Policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Inventories – In general the value of all inventories is determined by annual stock take as at 31st March or as close to that date as is reasonably practical. Inventories are valued at the lower of cost and net realisable value using the first-in first-out formula (except pharmacy stocks which are at weighted average cost).

Income Accruals – Where possible these are based on actual activity and price. Where it is not possible to quantify actual activity, accruals are estimated based on historical data available for the specific activity taking into account cyclical patterns where this is considered relevant.

Impairment of and Reversals of Financial Assets – All non-NHS receivables are assessed on an expected credit loss basis as required by IFRS 9. All debts relating to the Compensation Recovery Unit will be provided for at 21.89% as per the Accounting Manual guidance.

Expenditure Accruals – Where possible these are based on actual activity and price applicable. Where it is not possible to quantify actual activity, accruals are estimated based on historical data available for the specific activity taking into account cyclical patterns where this is considered relevant.

Employee Benefits – Accrual for untaken annual leave is based on number of days carried forward and calculated at the mid-point on the scale. Overtime and travel costs for March have been estimated based on the average of the preceding months.

Note 1.2.1 Sources of estimation uncertainty

There are no key assumptions concerning the future, or other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.3 Interests in other entities

The Isle of Wight NHS Trust Charitable Funds Accounts, for which the Isle of Wight NHS Trust is a Corporate Trustee, are not material and are therefore not consolidated.

Note 1.4 Revenue from contracts with customers

In line with the requirements under IFRS 15 - Revenue from Contracts with Customers, Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable.

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

In addition to healthcare related activities the Trust also trades under the name of NHS Creative. This activity is a design, print and marketing function. The income and costs related to this trade are included in Note 4 to the accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.2 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The Trust also makes contributions to an occupational pension scheme set up in accordance with the Automatic Enrolment (Miscellaneous Amendments) Regulations 2012. The scheme is a defined contribution scheme, for which the Trust accounts for its employer contributions within 'other pension costs' in these financial statements.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – modern equivalent asset value using the alternative site method (site optimisation)
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
 - management are committed to a plan to sell the asset
 - an active programme has begun to find a buyer and complete the sale
 - the asset is being actively marketed at a reasonable price
 - the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’ and
 - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

| | Min life Years | Max life Years |
|--------------------------------|-------------------|-------------------|
| Land | - | - |
| Buildings, excluding dwellings | 5 | 54 |
| Dwellings | - | - |
| Plant & machinery | 4 | 25 |
| Transport equipment | 5 | 15 |
| Information technology | 3 | 14 |
| Furniture & fittings | 5 | 17 |

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust’s business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

| | Min life Years | Max life Years |
|-------------------------|-------------------|-------------------|
| Information technology | 2 | 10 |
| Development expenditure | - | - |
| Websites | - | - |
| Software licences | - | - |
| Licences & trademarks | - | - |
| Patents | - | - |
| Other (purchased) | - | - |
| Goodwill | - | - |

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust’s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.12 Financial assets and financial liabilities**Note 1.12.1 Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.12.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.12.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 The trust as lessee**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The trust as lessor**Finance leases**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 28.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

- donated assets (including lottery funded assets),
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets accounts. The dividend thus calculated is not revised as set out in the "pre-audit" version of the annual should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Foreign exchange

The NHS trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury *FReM* adoption, with IFRS 16 being for implementation in 2019/20 and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the *FReM* early adoption is therefore not permitted

IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the *Frem*, early adoption is not permitted

IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019

The effect of the introduction of these new standards is currently not known or reasonably estimable.

Note 2 Operating Segments

The Board receives regular reports of the financial performance and financial position of the Trust, and as an integrated Trust the key financial information for decision making is based on the entity as a whole. It is therefore considered that the Trust has just one reportable segment, a healthcare segment. There are no other segments that constitute 10% or more of the Trust's operations. The Trust receives income from a number of healthcare commissioners, and the respective income levels are disclosed in note 3 to these accounts.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

| | 2018/19 £000 | 2017/18 £000 |
|---|-----------------|-----------------|
| Acute services | | |
| Elective income | 14,172 | 13,772 |
| Non elective income | 28,800 | 27,988 |
| First outpatient income | 4,968 | 4,822 |
| Follow up outpatient income | 3,924 | 3,819 |
| A & E income | 5,052 | 4,910 |
| High cost drugs income from commissioners (excluding pass-through costs) | 6,388 | 577 |
| Other NHS clinical income | 38,800 | 41,158 |
| Mental health services | | |
| Cost and volume contract income | - | - |
| Block contract income | 21,209 | 19,685 |
| Clinical partnerships providing mandatory services (including S75 agreements) | - | - |
| Clinical income for the secondary commissioning of mandatory services | - | - |
| Other clinical income from mandatory services | - | - |
| Ambulance services | | |
| A & E income | 5,467 | 6,549 |
| Patient transport services income | 1,789 | 700 |
| Other income | 4 | 4 |
| Community services | | |
| Community services income from CCGs and NHS England | 22,723 | 25,387 |
| Income from other sources (e.g. local authorities) | 3,943 | 4,559 |
| All services | | |
| Private patient income | 1,224 | 1,146 |
| Agenda for Change pay award central funding | 1,910 | - |
| Other clinical income | 398 | 453 |
| Total income from activities | 160,771 | 155,529 |

Note 3.2 Income from patient care activities (by source)

| Income from patient care activities received from: | 2018/19 £000 | 2017/18 £000 |
|--|-----------------|-----------------|
| NHS England | 11,072 | 9,275 |
| Clinical commissioning groups | 142,158 | 139,991 |
| Department of Health and Social Care | 1,910 | - |
| Other NHS providers | 66 | 105 |
| NHS other | - | - |
| Local authorities | 3,943 | 4,559 |
| Non-NHS: private patients | 1,224 | 1,146 |
| Non-NHS: overseas patients (chargeable to patient) | 28 | 55 |
| Injury cost recovery scheme | 313 | 368 |
| Non NHS: other | 57 | 30 |
| Total income from activities | 160,771 | 155,529 |
| Of which: | | |
| Related to continuing operations | 160,771 | 155,529 |
| Related to discontinued operations | - | - |

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

| | 2018/19 £000 | 2017/18 £000 |
|--|-----------------|-----------------|
| Income recognised this year | 28 | 55 |
| Cash payments received in-year | 11 | 46 |
| Amounts added to provision for impairment of receivables | 10 | 7 |
| Amounts written off in-year | 6 | 2 |

Note 4 Other operating income

| | 2018/19 £000 | 2017/18 £000 |
|---|-----------------|-----------------|
| Other operating income from contracts with customers: | | |
| Research and development (contract) | 808 | 834 |
| Education and training (excluding notional apprenticeship levy income) | 4,976 | 4,436 |
| Non-patient care services to other bodies | 5,297 | 5,640 |
| Provider sustainability / sustainability and transformation fund income (PSF / STF) | - | 469 |
| Income in respect of employee benefits accounted on a gross basis | 521 | 496 |
| Other contract income | 2,954 | 3,844 |
| Other non-contract operating income | | |
| Research and development (non-contract) | - | - |
| Education and training - notional income from apprenticeship fund | - | - |
| Receipt of capital grants and donations | 48 | 46 |
| Charitable and other contributions to expenditure | - | - |
| Support from the Department of Health and Social Care for mergers | - | - |
| Rental revenue from finance leases | - | - |
| Rental revenue from operating leases | 305 | 101 |
| Amortisation of PFI deferred income / credits | - | - |
| Other non-contract income | - | - |
| Total other operating income | 14,909 | 15,866 |
| Of which: | | |
| Related to continuing operations | 14,909 | 15,866 |
| Related to discontinued operations | - | - |

Material items included within Other Contract Income include NHS Creative Income Generation £1,757k, Car Parking £486k, Catering £459k, Estates Recharges £176k, Occupational Health Commercial £122k, Printroom £102k, Ferry Ticket sales £75k and Pharmacy Sales £49k

Note 5 Additional information on revenue from contracts with customers recognised in the period

| | 2018/19 £000 |
|--|-----------------|
| Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end | 459 |
| Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods | - |

Note 5.1 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:

| | 31 March 2019 £000 |
|---|-----------------------|
| within one year | - |
| after one year, not later than five years | - |
| after five years | - |
| Total revenue allocated to remaining performance obligations | - |

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Fees and charges

The Trust hosts NHS Creative and undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

| | 2018/19 £000 | 2017/18 £000 |
|----------------------------|-----------------|-----------------|
| Income | 1,757 | 1,866 |
| Full cost | (1,831) | (1,817) |
| Surplus / (deficit) | (74) | 49 |

Note 7 Operating expenses

| | 2018/19 £000 | 2017/18 £000 |
|---|-----------------|-----------------|
| Purchase of healthcare from NHS and DHSC bodies | 2,355 | 2,676 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | - | - |
| Purchase of social care | - | - |
| Staff and executive directors costs | 140,775 | 131,748 |
| Remuneration of non-executive directors | 85 | 73 |
| Supplies and services - clinical (excluding drugs costs) | 14,035 | 12,414 |
| Supplies and services - general | 1,970 | 1,714 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 13,955 | 12,585 |
| Inventories written down | 8 | 15 |
| Consultancy costs | 2,880 | 1,648 |
| Establishment | 3,110 | 3,395 |
| Premises | 7,536 | 6,975 |
| Transport (including patient travel) | 1,880 | 2,052 |
| Depreciation on property, plant and equipment | 5,879 | 5,583 |
| Amortisation on intangible assets | 852 | 901 |
| Net impairments | 105 | 3 |
| Movement in credit loss allowance: contract receivables / contract assets | (147) | |
| Movement in credit loss allowance: all other receivables and investments | - | 64 |
| Increase/(decrease) in other provisions | - | - |
| Change in provisions discount rate(s) | - | - |
| Audit fees payable to the external auditor | | |
| audit services- statutory audit | 78 | 76 |
| other auditor remuneration (external auditor only) | 10 | 10 |
| Internal audit costs | 71 | 57 |
| Clinical negligence | 2,781 | 3,856 |
| Legal fees | 388 | 245 |
| Insurance | 41 | 22 |
| Research and development | - | - |

| | 2018/19 £000 | 2017/18 £000 |
|---|-----------------|-----------------|
| Education and training | 687 | 570 |
| Rentals under operating leases | 748 | 710 |
| Early retirements | - | - |
| Redundancy | 242 | 122 |
| Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) | - | - |
| Charges to operating expenditure for off-SoFP PFI / LIFT schemes | - | - |
| Car parking & security | 331 | 321 |
| Hospitality | 96 | 105 |
| Losses, ex gratia & special payments | - | - |
| Grossing up consortium arrangements | - | - |
| Other services, eg external payroll | 174 | 144 |
| Other | 2,022 | 2,524 |
| Total | 202,947 | 190,608 |
| Of which: | | |
| Related to continuing operations | 202,947 | 190,608 |
| Related to discontinued operations | - | - |

Material items of Other Expenditure include External Contractors £1.636m, Patient Expenses £39k and Interpreting Services £26k

Note 7.1 Other auditor remuneration

| | 2018/19 £000 | 2017/18 £000 |
|---|-----------------|-----------------|
| Other auditor remuneration paid to the external auditor: | | |
| 1. Audit of accounts of any associate of the trust | - | - |
| 2. Audit-related assurance services | 10 | 10 |
| 3. Taxation compliance services | - | - |
| 4. All taxation advisory services not falling within item 3 above | - | - |
| 5. Internal audit services | - | - |
| 6. All assurance services not falling within items 1 to 5 | - | - |
| 7. Corporate finance transaction services not falling within items 1 to 6 above | - | - |
| 8. Other non-audit services not falling within items 2 to 7 above | - | - |
| Total | 10 | 10 |

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £0m).

Note 8 Impairment of assets

| | 2018/19 £000 | 2017/18 £000 |
|---|-----------------|-----------------|
| Net impairments charged to operating surplus / deficit resulting from: | | |
| Loss or damage from normal operations | - | 3 |
| Over specification of assets | - | - |
| Abandonment of assets in course of construction | - | - |
| Unforeseen obsolescence | - | - |
| Loss as a result of catastrophe | - | - |
| Changes in market price | - | - |
| Other | 105 | - |
| Total net impairments charged to operating surplus / deficit | 105 | 3 |
| Impairments charged to the revaluation reserve | 17,418 | - |
| Total net impairments | 17,523 | 3 |

Note 9 Employee benefits

| | 2018/19 Total £000 | 2017/18 Total £000 |
|--|--------------------------|--------------------------|
| Salaries and wages | 106,115 | 99,106 |
| Social security costs | 10,641 | 9,971 |
| Apprenticeship levy | 500 | 483 |
| Employer's contributions to NHS pensions | 12,223 | 11,725 |
| Pension cost - other | 21 | 10 |
| Other post employment benefits | - | - |
| Other employment benefits | - | - |
| Termination benefits | 242 | 122 |
| Temporary staff (including agency) | 11,678 | 10,891 |
| Total gross staff costs | 141,420 | 132,308 |
| Recoveries in respect of seconded staff | - | - |
| Total staff costs | 141,420 | 132,308 |
| Of which | | |
| Costs capitalised as part of assets | 403 | 438 |

Note 9.1 Retirements due to ill-health

During 2018/19 there were no early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £0k (£117k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

The Trust also makes contributions to an occupational pension scheme set up in accordance with the Automatic Enrolment (Miscellaneous Amendments) Regulations 2012. The scheme is a defined contribution scheme, for which the Trust accounts for its employer contributions within 'other pension costs' in these financial statements. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Note 11 Operating leases

Note 11.1 Isle of Wight NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Isle of Wight NHS Trust is the lessor.

The Leases comprise of rental of the Renal and Audiology Units by Portsmouth Hospitals NHS Trust and other smaller value leases of Land and Buildings.

| | 2018/19 £000 | 2017/18 £000 |
|--------------------------------|-----------------|-----------------|
| Operating lease revenue | | |
| Minimum lease receipts | 305 | 101 |
| Contingent rent | - | - |
| Other | - | - |
| Total | 305 | 101 |

| | 31 March 2019 £000 | 31 March 2018 £000 |
|--|-----------------------|-----------------------|
| Future minimum lease receipts due: | | |
| - not later than one year; | 305 | 98 |
| - later than one year and not later than five years; | 1,026 | 41 |
| - later than five years. | - | - |
| Total | 1,331 | 139 |

Note 11.2 Isle of Wight NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Isle of Wight NHS Trust is the lessee.

The Trust leases medical equipment, property and vehicles under operating lease arrangements.

| | 2018/19 £000 | 2017/18 £000 |
|---------------------------------|-----------------|-----------------|
| Operating lease revenue | | |
| Minimum lease payments | 748 | 710 |
| Contingent rents | - | - |
| Less sublease payments received | - | - |
| Total | 748 | 710 |

| | 31 March 2019 £000 | 31 March 2018 £000 |
|--|-----------------------|-----------------------|
| Future minimum lease receipts due: | | |
| - not later than one year; | 568 | 575 |
| - later than one year and not later than five years; | 487 | 602 |
| - later than five years. | 267 | 339 |
| Total | 1,322 | 1,516 |
| Future minimum sublease payments to be received | - | - |

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

| | 2018/19 £000 | 2017/18 £000 |
|--|-----------------|-----------------|
| Interest on bank accounts | 38 | 16 |
| Interest income on finance leases | - | - |
| Interest on other investments / financial assets | - | - |
| Other finance income | - | - |
| Total | 38 | 16 |

Note 13.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

| | 2018/19 £000 | 2017/18 £000 |
|---|-----------------|-----------------|
| Interest expense: | | |
| Loans from the Department of Health and Social Care | 1,169 | 652 |
| Other loans | - | - |
| Overdrafts | - | - |
| Finance leases | 15 | 18 |
| Interest on late payment of commercial debt | 2 | - |
| Main finance costs on PFI and LIFT schemes obligations | - | - |
| Contingent finance costs on PFI and LIFT scheme obligations | - | - |
| Total interest expense | 1,186 | 670 |
| Unwinding of discount on provisions | - | - |
| Other finance costs | - | 9 |
| Total finance costs | 1,186 | 679 |

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

| | 2018/19 £000 | 2017/18 £000 |
|--|-----------------|-----------------|
| Total liability accruing in year under this legislation as a result of late payments | - | - |
| Amounts included within interest payable arising from claims under this legislation | 2 | - |
| Compensation paid to cover debt recovery costs under this legislation | - | - |

Note 14 Other gains / (losses)

| | 2018/19 £000 | 2017/18 £000 |
|--|-----------------|-----------------|
| Gains on disposal of assets | - | - |
| Losses on disposal of assets | (36) | (4) |
| Total gains / (losses) on disposal of assets | (36) | (4) |
| Gains / (losses) on foreign exchange | - | (1) |
| Fair value gains / (losses) on investment properties | - | - |
| Fair value gains / (losses) on financial assets / investments | - | - |
| Fair value gains / (losses) on financial liabilities | - | - |
| Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI | - | - |
| Total other gains / (losses) | (36) | (5) |

Note 15 Discontinued operations

| | 2018/19 £000 | 2017/18 £000 |
|---|-----------------|-----------------|
| Operating income of discontinued operations | - | - |
| Operating expenses of discontinued operations | - | - |
| Gain on disposal of discontinued operations | - | - |
| (Loss) on disposal of discontinued operations | - | - |
| Corporation tax expense attributable to discontinued operations | - | - |
| Total | - | - |

Note 16 Intangible assets

Note 16.1 Intangible assets - 2018/19

| | Internally generated information technology £000 | Intangible assets under construction £000 | Total £000 |
|---|--|---|---------------|
| Valuation / gross cost at 1 April 2018 - brought forward | 8,369 | 183 | 8,552 |
| Transfers by absorption | - | - | - |
| Additions | 1,091 | 74 | 1,165 |
| Impairments | - | - | - |
| Reversals of impairments | - | - | - |
| Revaluations | - | - | - |
| Reclassifications | 154 | (154) | - |
| Transfers to / from assets held for sale | - | - | - |
| Disposals / derecognition | - | - | - |
| Valuation / gross cost at 31 March 2019 | 9,614 | 103 | 9,717 |
| Amortisation at 1 April 2017 - brought forward | 5,909 | - | 5,909 |
| Transfers by absorption | - | - | - |
| Provided during the year | 852 | - | 852 |
| Impairments | - | - | - |
| Reversals of impairments | - | - | - |
| Revaluations | - | - | - |
| Reclassifications | - | - | - |
| Transfers to / from assets held for sale | - | - | - |
| Disposals / derecognition | - | - | - |
| Amortisation at 31 March 2019 | 6,761 | - | 6,761 |
| Net book value at 31 March 2019 | 2,853 | 103 | 2,956 |
| Net book value at 1 April 2018 | 2,460 | 183 | 2,643 |

Note 16.2 Intangible assets - 2017/18

| | Internally generated information technology £000 | Intangible assets under construction £000 | Total £000 |
|--|--|---|---------------|
| Valuation / gross cost at 1 April 2017 - as previously stated | 6,800 | - | 6,800 |
| Prior period adjustments | - | - | - |
| Valuation / gross cost at 1 April 2017 - restated | 6,800 | - | 6,800 |
| Transfers by absorption | - | - | - |
| Additions | 1,572 | 183 | 1,755 |
| Impairments | - | - | - |
| Reversals of impairments | - | - | - |
| Revaluations | - | - | - |
| Reclassifications | - | - | - |
| Transfers to / from assets held for sale | - | - | - |
| Disposals / derecognition | (3) | - | (3) |
| Valuation / gross cost at 31 March 2018 | 8,369 | 183 | 8,552 |
| Amortisation at 1 April 2017 - as previously stated | 5,011 | - | 5,011 |
| Prior period adjustments | - | - | - |
| Amortisation at 1 April 2017 - restated | 5,011 | - | 5,011 |
| Transfers by absorption | - | - | - |
| Provided during the year | 901 | - | 901 |
| Impairments | - | - | - |
| Reversals of impairments | - | - | - |
| Revaluations | - | - | - |
| Reclassifications | - | - | - |
| Transfers to / from assets held for sale | - | - | - |
| Disposals / derecognition | (3) | - | (3) |
| Amortisation at 31 March 2018 | 5,909 | - | 5,909 |
| Net book value at 31 March 2018 | 2,460 | 183 | 2,643 |
| Net book value at 1 April 2017 | 1,789 | - | 1,789 |

Note 17 Property, plant and equipment

Note 17.1 Property, plant and equipment - 2018/19

| | Land £000 | Buildings excluding dwellings £000 | Dwellings £000 | Assets under construction £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Furniture & fittings £000 | Total £000 |
|---|--------------|---|-------------------|---|------------------------------|--------------------------------|-----------------------------------|---------------------------------|----------------|
| Valuation/gross cost at 1 April 2018 - brought forward | 8,895 | 105,209 | - | 3,570 | 12,999 | 1,994 | 3,921 | 1,712 | 138,300 |
| Transfers by absorption | - | - | - | - | - | - | - | - | - |
| Additions | 85 | - | - | 3,562 | 1,283 | 40 | 764 | 23 | 5,757 |
| Impairments | (1,670) | (15,853) | - | - | - | - | - | - | (17,523) |
| Reversals of impairments | - | - | - | - | - | - | - | - | - |
| Revaluations | 45 | 239 | - | - | - | - | - | - | 284 |
| Reclassifications | - | 6,101 | - | (6,688) | 84 | 27 | 476 | - | - |
| Transfers to / from assets held for sale | - | - | - | - | - | - | - | - | - |
| Disposals / derecognition | - | - | - | - | (90) | (26) | - | - | (116) |
| Valuation/gross cost at 31 March 2019 | 7,355 | 95,696 | - | 444 | 14,276 | 2,035 | 5,161 | 1,735 | 126,702 |
| Accumulated depreciation at 1 April 2018 - brought forward | - | 5,462 | - | - | 7,506 | 1,333 | 1,426 | 135 | 15,862 |
| Transfers by absorption | - | - | - | - | - | - | - | - | - |
| Provided during the year | - | 3,616 | - | - | 1,133 | 167 | 814 | 149 | 5,879 |
| Impairments | - | - | - | - | - | - | - | - | - |
| Reversals of impairments | - | - | - | - | - | - | - | - | - |
| Revaluations | - | (3,525) | - | - | - | - | - | - | (3,525) |
| Reclassifications | - | - | - | - | - | - | - | - | - |
| Transfers to / from assets held for sale | - | - | - | - | - | - | - | - | - |
| Disposals / derecognition | - | - | - | - | (30) | (26) | - | - | (56) |
| Accumulated depreciation at 31 March 2019 | - | 5,553 | - | - | 8,609 | 1,474 | 2,240 | 284 | 18,160 |
| Net book value at 31 March 2019 | 7,355 | 90,143 | - | 444 | 5,667 | 561 | 2,921 | 1,451 | 108,542 |
| Net book value at 1 April 2018 | 8,895 | 99,747 | - | 3,570 | 5,493 | 661 | 2,495 | 1,577 | 122,438 |

Note 17.2 Property, plant and equipment - 2017/18

| | Land £000 | Buildings excluding dwellings £000 | Dwellings £000 | Assets under construction £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Furniture & fittings £000 | Total £000 |
|--|--------------|---|-------------------|---|------------------------------|--------------------------------|-----------------------------------|---------------------------------|----------------|
| Valuation / gross cost at 1 April 2017 - as previously stated | 8,625 | 99,805 | - | 1,982 | 11,831 | 1,802 | 3,475 | 1,592 | 129,112 |
| Prior period adjustments | - | - | - | - | - | - | - | - | - |
| Valuation / gross cost at 1 April 2017 - restated | 8,625 | 99,805 | - | 1,982 | 11,831 | 1,802 | 3,475 | 1,592 | 129,112 |
| Transfers by absorption | - | - | - | - | - | - | - | - | - |
| Additions | - | - | - | 4,605 | 1,174 | 198 | 446 | 120 | 6,543 |
| Impairments | - | (3) | - | - | - | - | - | - | (3) |
| Reversals of impairments | - | - | - | - | - | - | - | - | - |
| Revaluations | 270 | 2,451 | - | - | - | - | - | - | 2,721 |
| Reclassifications | - | 2,956 | - | (3,017) | 61 | - | - | - | - |
| Transfers to / from assets held for sale | - | - | - | - | - | - | - | - | - |
| Disposals / derecognition | - | - | - | - | (67) | (6) | - | - | (73) |
| Valuation/gross cost at 31 March 2018 | 8,895 | 105,209 | - | 3,570 | 12,999 | 1,994 | 3,921 | 1,712 | 138,300 |
| Accumulated depreciation at 1 April 2017 - as previously stated | - | 5,463 | - | - | 6,455 | 1,190 | 603 | (6) | 13,705 |
| Prior period adjustments | - | - | - | - | - | - | - | - | - |
| Accumulated depreciation at 1 April 2017 - restated | - | 5,463 | - | - | 6,455 | 1,190 | 603 | (6) | 13,705 |
| Transfers by absorption | - | - | - | - | - | - | - | - | - |
| Provided during the year | - | 3,358 | - | - | 1,112 | 149 | 823 | 141 | 5,583 |
| Impairments | - | - | - | - | - | - | - | - | - |
| Reversals of impairments | - | - | - | - | - | - | - | - | - |
| Revaluations | - | (3,359) | - | - | - | - | - | - | (3,359) |
| Reclassifications | - | - | - | - | - | - | - | - | - |
| Transfers to / from assets held for sale | - | - | - | - | - | - | - | - | - |
| Disposals / derecognition | - | - | - | - | (61) | (6) | - | - | (67) |
| Accumulated depreciation at 31 March 2018 | - | 5,462 | - | - | 7,506 | 1,333 | 1,426 | 135 | 15,862 |
| Net book value at 31 March 2018 | 8,895 | 99,747 | - | 3,570 | 5,493 | 661 | 2,495 | 1,577 | 122,438 |
| Net book value at 1 April 2017 | 8,625 | 94,342 | - | 1,982 | 5,376 | 612 | 2,872 | 1,598 | 115,407 |

Note 17.3 Property, plant and equipment financing - 2018/19

| | Land £000 | Buildings excluding dwellings £000 | Dwellings £000 | Assets under construction £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Furniture & fittings £000 | Total £000 |
|--|--------------|---|-------------------|---|------------------------------|--------------------------------|-----------------------------------|---------------------------------|----------------|
| Net book value at 31 March 2019 | | | | | | | | | |
| Owned - purchased | 7,355 | 89,724 | - | 444 | 5,002 | 556 | 2,921 | 1,408 | 107,410 |
| Finance leased | - | - | - | - | 398 | - | - | - | 398 |
| On-SoFP PFI contracts and other service concession arrangements | - | - | - | - | - | - | - | - | - |
| Off-SoFP PFI residual interests | - | - | - | - | - | - | - | - | - |
| Owned - government granted | - | - | - | - | - | - | - | - | - |
| Owned - donated | - | 419 | - | - | 267 | 5 | - | 43 | 734 |
| NBV total at 31 March 2019 | 7,355 | 90,143 | - | 444 | 5,667 | 561 | 2,921 | 1,451 | 108,542 |

Note 17.4 Property, plant and equipment financing - 2017/18

| | Land £000 | Buildings excluding dwellings £000 | Dwellings £000 | Assets under construction £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Furniture & fittings £000 | Total £000 |
|--|--------------|---|-------------------|---|------------------------------|--------------------------------|-----------------------------------|---------------------------------|----------------|
| Net book value at 31 March 2018 | | | | | | | | | |
| Owned - purchased | 8,895 | 99,351 | - | 3,570 | 4,694 | 653 | 2,495 | 1,532 | 121,190 |
| Finance leased | - | - | - | - | 509 | - | - | - | 509 |
| On-SoFP PFI contracts and other service concession arrangements | - | - | - | - | - | - | - | - | - |
| Off-SoFP PFI residual interests | - | - | - | - | - | - | - | - | - |
| Owned - government granted | - | - | - | - | - | - | - | - | - |
| Owned - donated | - | 396 | - | - | 290 | 8 | - | 45 | 739 |
| NBV total at 31 March 2018 | 8,895 | 99,747 | - | 3,570 | 5,493 | 661 | 2,495 | 1,577 | 122,438 |

Note 18 Donations of property, plant and equipment

Donations towards equipment to the value of £48k have been provided by Friends of St.Marys Hospital.

Note 19 Revaluations of property, plant and equipment

Land and property assets are carried at valuation on the Statement of Financial Position. All of the Trust's land and building assets have been revalued as at 31 March 2019 by the District Valuers of the Revenue and Customs Government Department. The valuations have been carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and Social Care and HM Treasury.

Land and non-specialised buildings are now valued as modern equivalent asset value using the alternative site method (site optimisation) with the impact being a reduction to carrying values of £13.7m.

The Trust's plant and equipment assets continue to be carried at depreciated historical cost as a proxy for fair value. Property, plant and equipment is depreciated at rates calculated to write them down to estimated residual values on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets under construction.

Note 20 Inventories

| | 31 March 2019 £000 | 31 March 2018 £000 |
|--------------------------|-----------------------|-----------------------|
| Drugs | 981 | 878 |
| Work In progress | - | - |
| Consumables | 1,272 | 1,382 |
| Energy | 25 | 19 |
| Other | - | - |
| Total inventories | 2,278 | 2,279 |

Of which:

| | | |
|---------------------------------------|---|---|
| Held at fair value less costs to sell | - | - |
|---------------------------------------|---|---|

Inventories recognised in expenses for the year were £17,742k (2017/18: £15,781k).
Write-down of inventories recognised as expenses for the year were £8k (2017/18: £15k).

Note 21.1 Trade receivables and other receivables

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|-----------------------|-----------------------|
| Contract receivables* | 8,224 | |
| Contract assets* | - | |
| Trade receivables* | | 4,244 |
| Capital receivables | - | - |
| Accrued income* | | 3,899 |
| Allowance for impaired contract receivables / assets* | (225) | |
| Allowance for other impaired receivables | - | (392) |
| Deposits and advances | - | - |
| Prepayments (non-PFI) | 1,312 | 1,010 |
| PFI prepayments - capital contributions | - | - |
| PFI lifecycle prepayments | - | - |
| Interest receivable | - | - |
| Finance lease receivables | - | - |
| PDC dividend receivable | 327 | - |
| VAT receivable | 382 | 826 |
| Corporation and other taxes receivable | - | - |
| Other receivables | 532 | 1,023 |
| Total current trade and other receivables | 10,552 | 10,610 |

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|-----------------------|-----------------------|
| Non-current | | |
| Contract receivables* | - | |
| Contract assets* | - | |
| Trade receivables* | | - |
| Capital receivables | - | - |
| Accrued income* | | 286 |
| Allowance for impaired contract receivables / assets* | - | |
| Allowance for other impaired receivables | - | - |
| Deposits and advances | - | - |
| Prepayments (non-PFI) | - | - |
| PFI prepayments - capital contributions | - | - |
| PFI lifecycle prepayments | - | - |
| Interest receivable | - | - |
| Finance lease receivables | - | - |
| VAT receivable | - | - |
| Corporation and other taxes receivable | - | - |
| Other receivables | 251 | - |
| Total non-current trade and other receivables | 251 | 286 |

Of which receivables from NHS and DHSC group bodies:

| | | |
|-------------|-------|-------|
| Current | 6,128 | 5,773 |
| Non-current | - | - |

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 21.2 Allowances for credit losses - 2018/19

| | Contract receivables and contract assets £000 | All other receivables £000 |
|---|--|----------------------------------|
| Allowances as at 1 Apr 2018 - brought forward | | 392 |
| Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018 | 392 | (392) |
| Transfers by absorption | - | - |
| New allowances arising | 70 | - |
| Changes in existing allowances | (32) | - |
| Reversals of allowances | (185) | - |
| Utilisation of allowances (write offs) | (20) | - |
| Changes arising following modification of cotractual cash flows | - | - |
| Foreign exchange and other changes | - | - |
| Allowances as at 31 Mar 2019 | 225 | - |

Note 21.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

| | All receivables £000 |
|---|----------------------------|
| Allowances as at 1 Apr 2017 - as previously stated | 342 |
| Prior period adjustments | |
| Allowances as at 1 Apr 2017 - restated | 342 |
| Transfers by absorption | |
| Increase in provision | 64 |
| Amounts utilised | (14) |
| Unused amounts reversed | |
| Allowances as at 31 Mar 2018 | 392 |

Note 22 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

| | 2018/19 £000 | 2017/18 £000 |
|---|-----------------|-----------------|
| At 1 April | 5,999 | 7,295 |
| Prior period adjustments | - | - |
| At 1 April (restated) | 5,999 | 7,295 |
| Transfers by absorption | - | - |
| Net change in year | (1,512) | (1,296) |
| At 31 March | 4,487 | 5,999 |
| Broken down into: | | |
| Cash at commercial banks and in hand | 13 | 19 |
| Cash with the Government Banking Service | 4,474 | 5,980 |
| Deposits with the National Loan Fund | - | - |
| Other current investments | - | - |
| Total cash and cash equivalents as in SoFP | 4,487 | 5,999 |
| Bank overdrafts (GBS and commercial banks) | - | - |
| Drawdown in committed facility | - | - |
| Total cash and cash equivalents as in SoCF | 4,487 | 5,999 |

Note 22.1 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

| | 2018/19 £000 | 2017/18 £000 |
|---------------------------------|-----------------|-----------------|
| Bank balances | - | - |
| Monies on deposit | - | - |
| Total third party assets | - | - |

Note 23 Trade and other payables

| | 31 March 2019 £000 | 31 March 2018 £000 |
|--|-----------------------|-----------------------|
| Current | | |
| Trade payables | 8,803 | 7,341 |
| Capital payables | 2,225 | 3,803 |
| Accruals | 3,310 | 4,365 |
| Receipts in advance (including payments on account) | - | - |
| Social security costs | 2,798 | 2,735 |
| VAT payables | - | - |
| Other taxes payable | - | - |
| PDC dividend payable | - | 9 |
| Accrued interest on loans* | - | 72 |
| Other payables | 1,997 | 2,014 |
| Total current trade and other payables | 19,133 | 20,339 |
| Non-current | | |
| Trade payables | - | - |
| Capital payables | - | - |
| Accruals | 21 | 22 |
| Receipts in advance (including payments on account) | - | - |
| VAT payables | - | - |
| Other taxes payable | - | - |
| Other payables | - | - |
| Total non-current trade and other payables | 21 | 22 |
| Of which payables from NHS and DHSC group bodies: | | |
| Current | 1,620 | 2,980 |
| Non-current | - | - |

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 23.1 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

| | 31 March 2019 £000 | 31 March 2019 Number | 31 March 2018 £000 | 31 March 2018 Number |
|---|-----------------------|-------------------------|-----------------------|-------------------------|
| - to buy out the liability for early retirements over 5 years | - | | - | |
| - number of cases involved | | - | | - |

Note 24 Other financial liabilities

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|-----------------------|-----------------------|
| Current | | |
| Derivatives held at fair value through income and expenditure | - | - |
| Other financial liabilities | - | - |
| Total | - | - |
| Non-current | | |
| Derivatives held at fair value through income and expenditure | - | - |
| Other financial liabilities | - | - |
| Total | - | - |

Note 25 Other liabilities

| | 31 March 2019 £000 | 31 March 2018 £000 |
|--|-----------------------|-----------------------|
| Current | | |
| Deferred income: contract liabilities | 1,944 | 2,278 |
| Deferred grants | - | - |
| PFI deferred income / credits | - | - |
| Lease incentives | - | - |
| Other deferred income | - | - |
| Total other current liabilities | 1,944 | 2,278 |
| Non-current | | |
| Deferred income: contract liabilities | - | - |
| Deferred grants | - | - |
| PFI deferred income / credits | - | - |
| Lease incentives | - | - |
| Other deferred income | - | - |
| Net pension scheme liability | - | - |
| Total other non-current liabilities | - | - |

Note 26 Borrowings

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|-----------------------|-----------------------|
| Current | | |
| Bank overdrafts | - | - |
| Drawdown in committed facility | - | - |
| Loans from the Department of Health and Social Care | 238 | - |
| Other loans | - | - |
| Obligations under finance leases | 113 | 109 |
| PFI lifecycle replacement received in advance | - | - |
| Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle) | - | - |
| Total current borrowings | 351 | 109 |
| Non-current | | |
| Loans from the Department of Health and Social Care | 67,932 | 37,830 |
| Other loans | - | - |
| Obligations under finance leases | 308 | 422 |
| PFI lifecycle replacement received in advance | - | - |
| Obligations under PFI, LIFT or other service concession contracts | - | - |
| Total non-current borrowings | 68,240 | 38,252 |

Note 26.1 Reconciliation of liabilities arising from financing activities

| | Loans from DHSC £000 | Other loans £000 | Finance leases £000 | PFI and LIFT schemes £000 | Total £000 |
|---|-------------------------------|------------------------|---------------------------|------------------------------------|----------------|
| Carrying value at 1 April 2018 | 37,830 | - | 531 | - | 38,361 |
| Cash movements: | | | | | |
| Financing cash flows - payments and receipts of principal | 30,102 | - | (109) | - | 29,993 |
| Financing cash flows - payments of interest | (995) | - | (15) | - | (1,010) |
| Non-cash movements: | | | | | |
| Impact of implementing IFRS 9 on 1 April 2018 | 72 | - | - | - | 72 |
| Transfers by absorption | - | - | - | - | - |
| Additions | - | - | - | - | - |
| Application of effective interest rate | 1,169 | - | 15 | - | 1,184 |
| Change in effective interest rate | - | - | - | - | - |
| Changes in fair value | - | - | - | - | - |
| Other changes | (8) | - | (1) | - | (9) |
| Carrying value at 31 March 2019 | 68,170 | - | 421 | - | 68,591 |

Note 27 Finance leases

Note 27.1 Isle of Wight NHS Trust as a lessor

Future lease receipts due under finance lease agreements where Isle of Wight NHS Trust is the lessor:

| | 31 March 2019 £000 | 31 March 2018 £000 |
|--|-----------------------|-----------------------|
| Gross lease receivables | - | - |
| Of which those receivable: | | |
| - not later than one year; | - | - |
| - later than one year and not later than five years; | - | - |
| - later than five years. | - | - |
| Unearned interest income | - | - |
| Allowance for uncollectable lease payments | - | - |
| Net lease receivables | - | - |
| Of which those receivable: | | |
| - not later than one year; | - | - |
| - later than one year and not later than five years; | - | - |
| - later than five years. | - | - |
| The unguaranteed residual value accruing to the lessor | - | - |
| Contingent rents recognised as income in the period | - | - |

Note 27.2 Isle of Wight NHS Trust as a lessee

Obligations under finance leases where Isle of Wight NHS Trust is the lessee.

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|-----------------------|-----------------------|
| Gross lease receivables | 421 | 531 |
| Of which liabilities are due: | | |
| - not later than one year; | 113 | 109 |
| - later than one year and not later than five years; | 308 | 422 |
| - later than five years. | - | - |
| Finance charges allocated to future periods | - | - |
| Net lease liabilities | 421 | 531 |
| Of which payable: | | |
| - not later than one year; | 113 | 109 |
| - later than one year and not later than five years; | 308 | 422 |
| - later than five years. | - | - |
| Total of future minimum sublease payments to be received at the reporting date | - | - |
| Contingent rent recognised as an expense in the period | - | - |

Note 28.1 Provisions for liabilities and charges analysis

| | Pensions - early departure costs £000 | Pensions: injury benefits* £000 | Legal claims £000 | Re-structuring £000 | Equal Pay (including Agenda for Change) £000 | Redundancy £000 | Other £000 | Total £000 |
|--|--|--|----------------------|------------------------|--|--------------------|---------------|---------------|
| At 1 April 2018 | - | - | 115 | - | - | 122 | 240 | 477 |
| Transfers by absorption | - | - | - | - | - | - | - | - |
| Change in the discount rate | - | - | - | - | - | - | - | - |
| Arising during the year | - | - | 69 | - | - | 76 | 86 | 231 |
| Utilised during the year | - | - | (25) | - | - | (54) | (108) | (187) |
| Reclassified to liabilities held in disposal groups | - | - | - | - | - | - | - | - |
| Reversed unused | - | - | (49) | - | - | (68) | (47) | (164) |
| Unwinding of discount | - | - | - | - | - | - | - | - |
| At 31 March 2018 | - | - | 110 | - | - | 76 | 171 | 357 |
| Expected timing of cash flows: | | | | | | | | |
| - not later than one year; | - | - | 50 | - | - | 76 | 61 | 187 |
| - later than one year and not later than five years; | - | - | 60 | - | - | - | 110 | 170 |
| - later than five years. | - | - | - | - | - | - | - | - |
| Total | - | - | 110 | - | - | 76 | 171 | 357 |

Other provisions include figures for Industrial Tribunal cases (£61k) and provision for various property dilapidations (£110k).

It is not possible to be precise regarding dates of settlement for industrial injury and other legal claims and therefore there is uncertainty over the calculation and timings of amounts due.

Note 28.2 Clinical negligence liabilities

At 31 March 2019, £41,233k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Isle of Wight NHS Trust (31 March 2018: £23,068k).

Note 29 Contingent assets and liabilities

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|-----------------------|-----------------------|
| Value of contingent liabilities | | |
| NHS Resolution legal claims | - | - |
| Employment tribunal and other employee related litigation | - | - |
| Redundancy | - | - |
| Other | - | - |
| Gross value of contingent liabilities | - | - |
| Amounts recoverable against liabilities | - | - |
| Net value of contingent liabilities | - | - |
| Net value of contingent assets | - | - |

Note 30 Contractual capital commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

| | 31 March 2019 £000 | 31 March 2018 £000 |
|-------------------------------|-----------------------|-----------------------|
| Property, plant and equipment | 1,431 | 1,319 |
| Intangible assets | 20 | 144 |
| Total | 1,451 | 1,463 |

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's auditors.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Market risk

Because the Trust contracts mainly with other NHS bodies the risk that fair value of future cash flows of a financial instrument will fluctuate due to market risk (currency risk, interest rate risk and other market risk) is minimal.

Foreign Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Note 31.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

| | Held at amortised £000 | Held at fair value through I&E £000 | Held at fair value through OCI £000 | Total book value £000 |
|---|------------------------------|--|--|-----------------------------|
| Carrying values of financial assets as at 31 March 2019 under IFRS 9 | | | | |
| Trade and other receivables excluding non financial assets | 8,782 | - | - | 8,782 |
| Other investments / financial assets | - | - | - | - |
| Cash and cash equivalents at bank and in hand | 4,487 | - | - | 4,487 |
| Total at 31 March 2019 | 13,269 | - | - | 13,269 |

| | Loans and receivables £000 | Assets at fair value through the I&E £000 | Held to maturity £000 | Available- for-sale £000 | Total book value £000 |
|---|----------------------------------|--|-----------------------------|--------------------------------|-----------------------------|
| Carrying values of financial assets as at 31 March 2018 under IAS 39 | | | | | |
| Trade and other receivables excluding non financial assets | 8,498 | - | - | - | 8,498 |
| Other investments / financial assets | - | - | - | - | - |
| Cash and cash equivalents at bank and in hand | 5,999 | - | - | - | 5,999 |
| Total at 31 March 2018 | 14,497 | - | - | - | 14,497 |

Note 31.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

| | Held at amortised cost £000 | Held at fair value through the I&E £000 | Total book value £000 |
|--|-----------------------------------|--|-----------------------------|
| Carrying values of financial liabilities as at 31 March 2019 under IFRS 9 | | | |
| Loans from the Department of Health and Social Care | 68,170 | - | 68,170 |
| Obligations under finance leases | 421 | - | 421 |
| Obligations under PFI, LIFT and other service concession contracts | - | - | - |
| Other borrowings | - | - | - |
| Trade and other payables excluding non financial liabilities | 16,356 | - | 16,356 |
| Other financial liabilities | - | - | - |
| Provisions under contract | - | - | - |
| Total at 31 March 2019 | 84,947 | - | 84,947 |

| | Other financial liabilities £000 | Held at fair value through the I&E £000 | Total book value £000 |
|--|---|--|-----------------------------|
| Carrying values of financial liabilities as at 31 March 2018 under IAS 39 | | | |
| Loans from the Department of Health and Social Care | 37,830 | - | 37,830 |
| Obligations under finance leases | 531 | - | 531 |
| Obligations under PFI, LIFT and other service concession contracts | - | - | - |
| Other borrowings | - | - | - |
| Trade and other payables excluding non financial liabilities | 15,911 | - | 15,911 |
| Other financial liabilities | - | - | - |
| Provisions under contract | - | - | - |
| Total at 31 March 2018 | 54,272 | - | 54,272 |

Note 31.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 31.5 Maturity of financial liabilities

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|-----------------------|-----------------------|
| In one year or less | 16,686 | 16,020 |
| In more than one year but not more than two years | 37,967 | 112 |
| In more than two years but not more than five years | 30,294 | 38,140 |
| In more than five years | - | - |
| Total | 84,947 | 54,272 |

Note 32 Losses and special payments

| | 2018/19 | | 2017/18 | |
|--|------------------------------------|---------------------------------|------------------------------------|---------------------------------|
| | Total number of cases Number | Total value of cases £000 | Total number of cases Number | Total value of cases £000 |
| Losses | | | | |
| Cash losses | 3 | - | 1 | - |
| Fruitless payments | - | - | - | - |
| Bad debts and claims abandoned | 31 | 24 | 15 | 14 |
| Stores losses and damage to property | 17 | 4 | 13 | 13 |
| Total losses | 51 | 28 | 29 | 27 |
| Special payments | | | | |
| Compensation under court order or legally binding arbitration award | 6 | 25 | 2 | 3 |
| Extra-contractual payments | - | - | - | - |
| Ex-gratia payments | 9 | 3 | 14 | 2 |
| Special severance payments | - | - | - | - |
| Extra-statutory and extra-regulatory payments | - | - | - | - |
| Total special payments | 15 | 28 | 16 | 5 |
| Total losses and special payments | 66 | 56 | 45 | 32 |
| Compensation payments received | | - | | - |

Note 33 New Accounting Standards

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £72k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £562k.

Note 33.1 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of

promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 33.2 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019/20 and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM early adoption is therefore not permitted

IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the Frem, early adoption is not permitted

IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019

The effect of the introduction of these new standards is currently not known or reasonably estimable.

Note 34 Related parties

During the year none of the Department of Health and Social Care Ministers, Isle of Wight NHS Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Isle of Wight NHS Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Isle of Wight NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entries are :

| | 2018/19 | | 2017/18 | |
|---|-----------------------|-------------------|-----------------------|-------------------|
| | Expenditure £'000s | Revenue £'000s | Expenditure £'000s | Revenue £'000s |
| Isle of Wight CCG | 0 | 139,998 | 0 | 138,234 |
| NHS England - Wessex | 28 | 10,763 | 0 | 9,181 |
| University Hospital Southampton NHS Foundation Trust | 904 | 1,132 | 1,058 | 694 |
| Portsmouth Hospitals NHS Trust | 3,382 | 489 | 3,318 | 591 |
| NHS Resolution (formerly NHS Litigation Authority) | 2,781 | 0 | 3,856 | 0 |

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with HM Revenue and Customs, NHS Pensions Agency and the Isle of Wight Council.

The Trust has also received revenue and capital payments from the NHS Trust's charitable funds currently registered with the Charity Commission under number 1049606 in the name of Isle of Wight NHS Trust Charitable Funds. The Corporate Trustee of the charitable funds is Isle of Wight NHS Trust. The Trust makes purchases on behalf of the Charity in accordance with Standing Financial Instructions and procurement procedures for which the Charity reimburses the Trust on a monthly basis.

| | 2018/19 £000 | 2018/19 £000 | 2017/18 £000 | 2017/18 £000 |
|---|-----------------|-----------------|-----------------|-----------------|
| Non-NHS Payables | | | | |
| Total non-NHS trade invoices paid in the year | 27,994 | 65,189 | 26,676 | 60,014 |
| Total non-NHS trade invoices paid within target | 20,407 | 41,688 | 22,327 | 44,689 |
| Percentage of non-NHS trade invoices paid within target | 72.9% | 63.9% | 83.7% | 74.5% |
| Non-NHS Payables | | | | |
| Total NHS trade invoices paid in the year | 2,825 | 7,491 | 2,633 | 5,711 |
| Total NHS trade invoices paid within target | 1,589 | 2,745 | 2,313 | 4,617 |
| Percentage of NHS trade invoices paid within target | 56.2% | 36.6% | 87.8% | 80.8% |

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 36 External financing

The trust is given an external financing limit against which it is permitted to underspend:

| | 2017/18 £000 | 2016/17 £000 |
|---|-----------------|-----------------|
| Cash flow financing | 31,644 | 25,950 |
| Finance leases taken out in year | - | - |
| Other capital receipts | - | - |
| External financing requirement | 31,644 | 25,950 |
| External financing limit (EFL) | 33,251 | 29,934 |
| Under / (over) spend against EFL | 1,607 | 3,984 |

Note 37 Capital Resource Limit

| | 2018/19 £000 | 2017/18 £000 |
|--|-----------------|-----------------|
| Gross capital expenditure | 6,922 | 8,298 |
| Less: Disposals | (60) | (6) |
| Less: Donated and granted capital additions | (48) | (46) |
| Plus: Loss on disposal from capital grants in kind | - | - |
| Charge against Capital Resource Limit | 6,814 | 8,246 |
| Capital Resource Limit | 6,820 | 9,230 |
| Under / (over) spend against CRL | 6 | 984 |

Note 37 Breakeven duty financial performance

| | 2018/19 £000 |
|--|-----------------|
| Adjusted financial performance surplus / (deficit) (control total basis) | (30,102) |
| Remove impairments scoring to Departmental Expenditure Limit | - |
| Add back non-cash element of On-SoFP pension scheme charges | - |
| IFRIC 12 breakeven adjustment | - |
| Breakeven duty financial performance surplus / (deficit) | (30,102) |

Note 39 Breakeven duty rolling assessment

| | 1997/98 to 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|-----------------------|---------|---------|---------|---------|---------|---------|---------|----------|----------|----------|
| Breakeven duty in-year financial performance | | - | - | - | 543 | 1,613 | 15 | (8,358) | (10,960) | (22,664) | (30,102) |
| Breakeven duty cumulative position | - | - | - | - | 543 | 2,156 | 2,171 | (6,187) | (17,147) | (39,811) | (69,913) |
| Operating income | | - | - | - | 168,757 | 171,867 | 174,386 | 170,276 | 171,110 | 171,395 | 175,680 |
| Cumulative breakeven position as a percentage of operating income | | 0.0% | 0.0% | 0.0% | 0.3% | 1.3% | 1.2% | (3.6%) | (10.0%) | (23.2%) | (39.8%) |

Although the Trust has not met its Breakeven duty for the past four years it has been working closely with NHS Improvement who are fully aware of the reasons behind this. Being placed in Financial Special Measures will provide the support required to develop longer term recovery plans to enable the Trust to achieve financial sustainability.

The role of the auditor

External auditors have two broad objectives:

- To review and report on the Trust's annual accounts and statement on governance; and
- To review whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Auditors are required to comply with the Code of Audit Practice (published by the Audit Commission) and International Standards on Auditing (United Kingdom and Ireland) (ISAs (UK&I)).

The appointed auditor will audit the Trust's annual accounts and give an opinion stating whether the accounts give a true and fair view of the organisation's affairs at the end of the financial year.

Auditors will also consider the Annual Report and make a statement, in their audit opinion, if its contents are inconsistent with their knowledge of the organisation.

In addition to their opinion on the accounts, auditors are also required to issue:

- A report to those charged with governance (in most cases the Audit Committee) incorporating the report required under ISA (UK&I) 260 and setting out the main matters arising from the audit of the annual accounts; and
- An annual audit letter summarising the key issues arising from audit work throughout the year.

Auditors also have special reporting powers and can issue a public interest report or make a referral to the Secretary of State.

[Note: For submission of the annual report and accounts to NHS Improvement, the independent auditor's report has been uploaded separately to the NHS Improvement portal. The report will be included as part of the final published version of the Annual Report and Accounts.]

This glossary is intended to clarify NHS-specific terms used in this document. If you cannot find the definition you are looking for, try here: www.england.nhs.uk/participation/resources/involvejargon.

CCG – Clinical Commissioning Group

A clinically-led group that includes all of the GP groups in the geographical area. An NHS organisation set up by the Health & Social Care Act 2012 to organise the delivery of NHS services in England.

CQC – Care Quality Commission

The independent regulator of all health and social care services in England.

DHSC – Department of Health and Social Care

The Department of Health and Social Care (DHSC) is a department of the UK government responsible for health and adult social care policy matters in England, along with a few elements of the same matters which are not otherwise devolved to the Scottish Government, Welsh Government or Northern Ireland Executive. It oversees the NHS.

IM&T – Information Management & Technology

An umbrella term for the processes, systems, hardware and software a company uses to conduct its day-to-day operations.

ICS – Integrated Care System

A close collaboration with NHS organisations, in partnership with local councils and others, taking collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

Isle of Wight Local Care Board

A collaboration between the Isle of Wight NHS Trust, Isle of Wight Council and Isle of Wight Clinical Commissioning Group.

Isle of Wight Health and Care Sustainability Plan

Produced by the Isle of Wight Local Care Board, the Isle of Wight Health and Care Sustainability Plan outlines the anticipated challenges and plans for delivering services to our population over the next three years.

KPIs – Key Performance Indicators

A way of monitoring and managing performance against a pre-determined target.

NHS Long Term Plan

Published in January 2019, this plan sets out how the NHS will spend its funding over the next 10 years to improve health and care services across the country.

NHSE / NHSI – NHS England & NHS Improvement

From 1 April 2019, NHS England and NHS Improvement came together to act as a single organisation to better support the NHS and help improve care for patients.

NICE – National Institute for Health and care Excellence

Provides national guidance and advice to improve health and social care.

RTT – Referral to treatment

The time it takes between a GP referral and a definitive secondary care treatment being provided.

Special measures

Special measures apply when NHS trusts and foundation trusts have serious problems and there are concerns that the existing leadership cannot make the necessary improvements without support.

STP – Sustainability and Transformation Partnerships

These are areas covering all of England, where local NHS organisations and councils drew up shared proposals to improve health and care in the areas they serve.

Get in touch or get involved

Get in touch or get involved

We want to know what you think of your NHS. How can we improve? You can make a difference by...

- Joining the Trust as a public member – and if you have time to spare, why not become one of our valued volunteers?
- Attending our Medicine for Members meetings and other events
- Becoming a Quality Champion (if you're a member of staff) and taking an active role in one of the many initiatives designed to improve the patient and staff experience
- Becoming a member of our Patient Council

Please get in touch. Telephone: **01983 822099** ext. 5703 or e-mail membership@iow.nhs.uk

Tell us what you think

The Isle of Wight NHS Trust welcomes feedback and questions from staff, stakeholders, members and the wider public on this document and any other issue relating to our services. If you have feedback please contact the Corporate Communications, Engagement and Membership Team:

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